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No. 10-283

In The
Supreme Court of the United States

DAVID MAXWELL-JOLLY, Director, California Department of Health Care Services,

Petitioner,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether those injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law.

2. Whether a state law reducing Medicaid reimbursement rates is preempted by the federal law governing such rate-setting, 42 U.S.C. § 1396a(a)(30)(A).

CORPORATE DISCLOSURE STATEMENT

CHILDREN'S HOSPITAL AT MISSION, a California corporation, dba CHOC Children's at Mission, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

FOUNTAIN VALLEY REGIONAL HOSPITAL AND MEDICAL CENTER, a California corporation, is 100% owned by OrNda Hospital Corporation, a California corporation that is 100% owned by Tenet HealthSystem HealthCorp, a Delaware corporation that is 100% owned by Tenet Healthcare Corporation (NYSE: THC), a publicly-held Nevada corporation. As of June 30, 2010, only one company reported to the Securities and Exchange Commission that it beneficially owned more than 10% of Tenet Healthcare Corporation's publicly traded common stock: Franklin Mutual Advisers, LLC (10.6%), which is not itself a publicly-held company, but is a subsidiary of a publicly-held company, Franklin Resources Inc. (NYSE: BEN).

HEART HOSPITAL OF BK, LLC, a North Carolina limited liability company, dba Bakersfield Heart Hospital, is owned by Heart Hospital of BK, LLC (the "Company"), a North Carolina limited liability company. As of September 30, 2008, HHBF, Inc., an indirectly owned subsidiary of MedCath Corporation ("MedCath"), held a 53.3% interest in the Company, and the physician members held the remaining 46.7% interest. MedCath is publicly traded on the NASDAQ under the symbol "MDTH."

CORPORATE DISCLOSURE STATEMENT – Continued

HOAG MEMORIAL HOSPITAL PRESBYTERIAN, a California corporation, dba Hoag Memorial Hospital Presbyterian in Newport Beach, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

JOHN MUIR HEALTH, a California corporation, dba John Muir Medical Center – Concord Campus and as John Muir Medical Center – Walnut Creek Campus, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

LANCASTER HOSPITAL CORPORATION, a California corporation, dba Lancaster Community Hospital, is owned by Universal Health Services of Palmdale, Inc., which is not a publicly traded company. The stock of Universal Health Services of Palmdale, Inc. is wholly owned by Universal Health Services, Inc., which is a publicly traded company. There are no publicly-held companies that own more than 10% of the stock of Universal Health Services, Inc.

ORANGE COAST MEMORIAL MEDICAL CENTER, a California corporation, ANAHEIM MEMORIAL MEDICAL CENTER, a California corporation, and SADDLEBACK MEMORIAL MEDICAL CENTER, a California corporation, have as a parent

CORPORATE DISCLOSURE STATEMENT – Continued

corporation MEMORIAL HEALTH SERVICES, a California corporation. No publicly-held company owns any stock in the above-named respondents or parent corporation.

SAN ANTONIO COMMUNITY HOSPITAL, a California corporation, has no parent corporation, and no publicly-held company owns any stock in the above-named respondent.

SANTA ROSA MEMORIAL HOSPITAL, SRM ALLIANCE HOSPITAL SERVICES, a California corporation, dba Petaluma Valley Hospital, QUEEN OF THE VALLEY MEDICAL CENTER, a California corporation, and MISSION HOSPITAL REGIONAL MEDICAL CENTER, a California corporation, dba Mission Hospital, are all non-profit corporations. No publicly-held company owns any stock in the above-named respondents.

ST. HELENA HOSPITAL, a California corporation, CENTRAL VALLEY GENERAL HOSPITAL, a California corporation, and SAN JOAQUIN COMMUNITY HOSPITAL, a California corporation, have as a parent corporation ADVENTIST HEALTH SYSTEMS/WEST, a California corporation. No publicly-held company owns any stock in the above-named respondents or parent corporation.

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INTRODUCTION

There are no grounds for review here.[1] This case involves no conflict between the decisions of Federal courts of different circuits. Moreover, the Ninth Circuit's application of 42 U.S.C. § 1396a(a)(30)(A) is consistent with its plain terms and the interpretation of that statute by the federal CMS (Centers for Medicare & Medicaid Services).

Even if legitimate grounds for certiorari existed, this case would be a poor vehicle for review for at least three reasons. First, the decision that the petitioner seeks to have reviewed is based on a preliminary injunction, and not a final action. Review of such interlocutory decisions is strongly disfavored. Second, the rate change at issue here has not been approved, and may never be approved, by the federal CMS. Administrative disapproval of petitioner's rate change would make the decision of this Court moot. Third, this Court does not grant review in cases where a reversal would not change the position of the parties in some concrete fashion. In the instant action, a reversal would not change the ultimate outcome of the case because respondents can pursue

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[1] Respondents agree with petitioner that this case involves "substantially the same legal issues as the petitions for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958. . .and *Maxwell-Jolly v. California Pharmacists Association*, No. 09-1158[.]" Pet. 3. For the reasons set forth herein, and in the other cases, the petitions in all of these cases should be denied.

their claims in State court under a writ of mandate (Cal. Code of Civil Procedure § 1085).

STATEMENT

A. Statutory Framework

The State pays California hospitals for the inpatient services they provide to Medi-Cal beneficiaries in one of two ways. Under one approach, the California Medical Assistance Commission ("CMAC") negotiates contracts with selected hospitals. This system of reimbursement is known as the selective provider contracting program, and the hospitals that participate in it are called "contracting" hospitals. The State of California did not reduce the negotiated rates paid contract hospitals; hence, those types of facilities are not relevant to this lawsuit. Pet. App. 25.

Hospitals that do not have a contract are typically referred to as "noncontract" hospitals. For over twenty-five years (from 1982 through 2008), the State paid noncontract hospitals based on their "allowable costs," and then applied two different and highly sophisticated measures of "economy" and "efficiency" to those costs, the rate per discharge limit and the peer group limit. *See* App., *infra*, 1-85; 22 California Code of Regulations (C.C.R.) §§ 51545-51555. If a hospital's "allowable costs" fell below the rate per discharge limit and the peer group limit, then those costs were fully reimbursed as the costs of an "[e]conomically and [e]fficiently [o]perated" provider

of inpatient services. *See* App., *infra*, 5, 12-13; 22 C.C.R. §§ 51545(a)(30) and 51545(a)(70). This approach – which was based on sophisticated measures of "economy" and "efficiency" – had been approved by the federal CMS as complying with federal law.

In 2008, without federal approval, the State completely abandoned the sophisticated reimbursement methodology described above. On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 (AB 5) in special session which, effective July 1, 2008, imposed an across-the-board ten percent reduction in the "allowable cost" reimbursement of *all* noncontract hospitals for the inpatient services they provide Medi-Cal recipients. Cal. Welf. & Inst. Code § 14166.245 (Pet. App. 25-41). Then, effective October 1, 2008, California enacted AB 1183 which further cut the amounts paid to noncontract hospitals to the lesser of the above-described 10% reduction or to the applicable CMAC average contract rate less 5 percent.[2] Cal. Welf. & Inst. Code § 14166.245 (Pet. App. 25-41).

Respondents showed that without an injunction of both AB 5 and AB 1183 they would have lost between 21% and 37% of their inpatient Medi-Cal reimbursement, which translated into an annual loss

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[2] In the instant case, respondents sought to enjoin only the rate cut under AB 5 because the rate reduction under AB 1183 had already been enjoined by the Ninth Circuit on April 6, 2009, in *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009). Pet. 11.

of between $40 and $55 million per year. Moreover, respondents submitted fifteen declarations which were virtually uncontested and unrefuted showing that they would have to curtail or eliminate significant programs, services, and capital expenditures as a result of the petitioner's draconian rate cuts.

Petitioner readily admits that both rate reductions were enacted predominantly for budgetary reasons. Furthermore, as of October 12, 2010, neither rate reduction had been approved by the federal CMS.

B. Factual Background

The respondents are nineteen hospitals located throughout California that provide services to Medi-Cal beneficiaries.

On November 14, 2008, respondents filed a Complaint in the Northern District of California challenging the validity of the AB 5 and the AB 1183 Medi-Cal rate reductions, and seeking a preliminary injunction enjoining the implementation of those rate cuts. Respondents subsequently amended their Complaint on December 4, 2009, primarily to add additional plaintiffs.

On January 14, 2009, respondents filed a motion for a preliminary injunction enjoining the application of the AB 5 and the AB 1183 rate cuts. The district court stayed the case in its entirety pending the

Ninth Circuit's decision in *Indep. Living Ctr. of Southern Cal., Inc. v. Shewry* and denied respondents' motion for a preliminary injunction without prejudice.

Plaintiffs appealed the denial of the preliminary injunction and requested that the Ninth Circuit grant an emergency injunction. On June 2, 2009, the Ninth Circuit vacated and remanded the appeal because the district court made no findings or conclusions in support of its order denying the preliminary injunction motion.

On June 4, 2009, the district court requested "supplemental brief[s]. . .explaining whether the Ninth Circuit's April 6, 2009 Order, *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009), requires the Court to enjoin the Medi-Cal reimbursement rate cuts at issue in the present case."

On June 12, 2009, respondents filed their Supplemental Memorandum to Enjoin AB 5, and on June 17, 2009, the petitioner filed a response. On June 26, 2009, without deciding respondents' motion to enjoin AB 5, the district court continued its stay of the case pending a hearing on the motion of plaintiffs *Santa Rosa Memorial Hospital, et al.*, for centralization of this case with others in the United States District Court for the Central District of California.

On September 9, 2009, after respondents' request for centralization was denied, the district court lifted the stay and invited the respondents to file an Amended Motion for Preliminary Injunction: "This case is no longer stayed. Based on recent Ninth

Circuit decisions, including *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. July 9, 2009), the Court will allow Plaintiffs – if they so desire – to file a new brief in support of an Amended Motion for Preliminary Injunction."

On November 18, 2009, after extensive briefing, the district court granted respondents' Amended Motion for Preliminary Injunction of the AB 5 rate cuts.

However, on the very next day, November 19, 2009, in response to a letter request from the petitioner, the district court stayed the case again. On November 23, 2009, respondents filed a Motion to Vacate Stay and to Restore Preliminary Injunction, which the district court granted on December 2, 2009.

After the court restored the preliminary injunction, the petitioner refused to reinstate the pre-AB 5 interim rates. As a result, on December 8, 2009, respondents moved for an Order to Show Cause as to why the petitioner should not be held in contempt for violating the preliminary injunction Order by continuing to implement and apply the ten percent reduction to the interim Medi-Cal payments to the respondents. On December 10, 2009, the district court issued a Clarifying Order confirming that "its preliminary injunction was always intended to enjoin the ten percent reductions in both interim and final payments."

A few hours after the district court issued its Clarifying Order, the petitioner sent a letter to the district court requesting that respondents post a bond and that the court again stay the preliminary injunction pending the submission of evidence and argument on the amount of the bond. Respondents objected to the petitioner's requests. On December 16, 2009, the district court issued an order denying petitioner's request for a bond. Petitioner appealed.

On May 27, 2010, the Ninth Circuit issued its decision. The Court noted that the instant appeal is controlled by *Cal. Pharm. Ass'n v. Maxwell-Jolly*, because both AB 1183 and AB 5 give "the Department of Health Care Services no discretion to alter the rate cuts at issue here." Pet. App. 2. It also noted that "[t]he Director's attempts to distinguish *Cal. Pharmacists Association* are unavailing." Pet. App. 2. Thus, it affirmed the district court holding "that Plaintiffs demonstrated a likelihood of success on the merits that the rate reductions violate 42 U.S.C. § 1396a(a)(30)(A)[.]" Pet. App. 2.

REASONS THE PETITION SHOULD BE DENIED

I. CERTIORARI SHOULD BE DENIED ON THE FIRST QUESTION BECAUSE THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THIS COURT'S SETTLED SUPREMACY CLAUSE JURISPRUDENCE

Petitioner argues that "review is warranted because the Ninth Circuit's decision on this [preemption] issue conflicts with this Court's precedent establishing limits on private rights of action against the states." Pet. 16. By this statement, petitioner apparently is making two claims: (1) that respondents' Supremacy Clause claim should be dismissed because it does not meet the standards for maintaining a private right of action under 42 U.S.C. § 1983, and (2) that Congress did not intend to create a private right of action under 42 U.S.C. § 1396a(a)(30)(A). Neither claim has merit.

A. The Courts Do Not Require That Preemption Claims Meet The Same Standards As Claims Under Section 1983

This Court has *never* held that a claim for injunctive relief based on federal preemption must meet the standards for bringing an action under Section 1983. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), several large employers brought suit against the Acting Commissioner of the New York State Division of Human Rights claiming that the State's Human

Rights and Disability Benefits Laws were preempted by the federal Employee Retirement Income Security Act ("ERISA"). The Court held that the state legislation was preempted insofar as it prohibited practices that were unlawful under ERISA. The Court explained,

> [i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.

463 U.S. at 96 n.14; *see also Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 259 n.6 (1985) (describing *Shaw* as "reaffirming the general rule" that a plaintiff asserting preemption under the Supremacy Clause has stated a federal claim for injunctive relief); *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973) (enjoining a city ordinance preempted by the Federal Aviation Act); *Ray v. Atlantic Richfield Co.*, 435 U.S. 151 (1978) (enjoining the State of Washington's Tanker Law because it was preempted by the federal Ports and Waterways Safety Act); *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992) (holding that state licensing acts are preempted by the federal Occupational Safety and Health Act of 1979);

Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n, 461 U.S. 190 (1983); *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963).

Petitioner's argument fails to recognize that preemption and Section 1983 are completely different and separate avenues for enforcing federal law. The remedies available under Section 1983 are far more extensive than under preemption. Under Section 1983, a plaintiff can obtain compensatory and punitive damages against state actors in their individual capacities, compensatory damages against municipalities, and attorneys' fees. *See City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247 (1981); 42 U.S.C. § 1988. In contrast, a plaintiff with a preemption claim can seek only to enforce "the proper constitutional structural relationship between the state and federal governments." *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009).

Indeed, several members of this Court have stressed that preemption claims and Section 1983 serve different purposes and have different requirements. In *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), for example, Justice Kennedy explained that even though he would have held that the plaintiff could not bring its action under Section 1983, nevertheless:

> we would not leave the [plaintiff] without a remedy. Despite what one might think from the increase of litigation under the statute in recent years, § 1983 does not provide the exclusive relief that the federal courts

> have to offer. . . . [P]laintiffs may vindicate [statutory] preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes.

Id. at 119 (Kennedy, J., dissenting) (citations omitted).

B. A Supremacy Clause Claim Does Not Depend On A Private Right Of Action

Petitioner also suggests that Congress did not intend to create a private right of action under 42 U.S.C. § 1396a(a)(30)(A). *See, e.g., Cort v. Ash*, 422 U.S. 66 (1975); *Alexander v. Sandoval*, 532 U.S. 275 (2001). That concept, however, is irrelevant because the remedy in the instant case is supplied by the Supremacy Clause, and does not depend upon an implied private right of action. As this Court has explained, "the existence of conflict cognizable under the Supremacy Clause does not depend on express congressional recognition that federal and state law may conflict." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 388 (2000); *see also Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635 (2002) (rejecting the assertion that a district court could not reach the merits of a preemption claim unless the plaintiff had demonstrated a statutory cause of action).

C. The Committee Reports Relating To The Boren Amendment Are Irrelevant

Petitioner cites a few sentences from Committee reports relating to the Boren Amendment, and jumps to the conclusion that "Congress, in repealing the Boren Amendment, evinced a clear intent. . .to preclude [all] private provider challenges[.]" Pet. 17. Petitioner is wrong.

The Boren Amendment (42 U.S.C. § 1396a(a)(13)(A)) and Section 1396a(a)(30)(A) are separate and distinct provisions of the Medicaid Act. At the time of the Boren Amendment's repeal, Section 1396a(a)(30)(A) had consistently been held to impose an independent, enforceable requirement in establishing reimbursement standards for provider services. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998); *Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996), *cert. denied*, 519 U.S. 1114 (1997); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993). The Boren Amendment's "repeal, like its enactment, modified § 13(A) alone; it effected no change to § 30(A)." *Alaska Dep't of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-941 (9th Cir. 2005).

Petitioner's reliance on a 1997 committee report discussing the repeal of the Boren Amendment that described the repeal as precluding enforcement by providers of "any other" provision of Section 1396a,

H.R. Rep. No. 105-149, at 591 (1997), does not alter the fact that the text of Section 1396a(a)(30)(A) was not amended in 1997. Thus, the legislative history cited by petitioner is irrelevant. *See Doe v. Chao*, 540 U.S. 614, 626-627 (2004).

The legislative history cited by petitioner is also irrelevant for two additional reasons. Because respondents are not relying upon an implied private right of action to enforce Section 1396a(a)(30)(A), but instead are relying upon the Supremacy Clause, Congressional intent is not relevant. Also, when a State makes the decision to participate in the Medicaid program, it is bound to comply with federally imposed conditions, irrespective of whether or not the law contains a congressionally created implied private right of action. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

D. Over Half Of The Medicaid Expenditures In California Are Paid For With Federal Dollars

Although petitioner complains of the cost to comply with federal law (*see*, Pet. 20), the federal government matches or exceeds State dollars for Medi-Cal. The federal government paid half of California's Medi-Cal expenditures prior to October 2008, and will pay more than half of California's Medi-Cal expenditures for the period of October 2008 to December 2010 pursuant to the *American Recovery and Reinvestment Act of 2009* (hereinafter "*ARRA*"), Pub.

L. No. 111-5, 123 Stat. 115. Under the *ARRA*, the federal government is expected to spend over $11 billion on Medi-Cal for that period. Kaiser Commission on Medicaid and the Uninsured, *American Recovery and Reinvestment Act (AARA): Medicaid and Health Care Provisions* (Mar. 2009), at http://www.kff.org/medicaid/upload/7872.pdf. In return for this infusion of billions of federal dollars, it is only right that the State of California be required to comply with federal law.

E. There Is A Dearth Of Successful Supremacy Clause Cases Outside Of California

Petitioner baldly asserts that "DHCS is aware of over 40 Supremacy Clause lawsuits across the country that have been spurred by the Ninth Circuit's *Independent Living* decisions." Pet. 20. This statement should be rejected for several reasons. The Court has no way of knowing if the statement is correct because petitioner did not provide any details to support it; nor does petitioner demonstrate whether the rate at which Supremacy Clause cases are being filed has increased, decreased, or remained the same from prior years. Also, even though petitioner claims that the *Independent Living* decisions "spurred" the Supremacy Clause lawsuits, petitioner does not and cannot establish a causal connection between these two events. Indeed, since the *Independent Living Center* ("*ILC*") decisions are based on this Court's settled Supremacy Clause jurisprudence,

it is unlikely that the *ILC* cases were an instigating factor in any of the 40 cases cited by petitioner.

In connection with its petition for certiorari in *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, U.S. Supreme Court Case No. 09-0958, the petitioner here submitted detailed case information concerning the Supremacy Clause lawsuits that have been filed. *Id.* at Pet. App. 211a-223a. Based on that information, it is clear that only 14 Supremacy Clause cases were filed in federal courts outside of California, and that injunctions were issued in only two of those cases. *Id.* Thus, there is not an epidemic of Supremacy Clause cases outside of California, and the results of the few lawsuits that do exist demonstrate that States that properly follow the mandates of federal Medicaid law (as most do, except California) will not lose any Medicaid monies.

F. The Courts Of Appeals Have Uniformly Reached The Same Conclusion As The Court Below

Petitioner claims that "[r]eview is also warranted to resolve a conflict among the courts of appeals on this [preemption] issue." Pet. 18. Petitioner is wrong here too.

Petitioner readily admits that "[t]he D.C., Fifth, Eighth, and Ninth Circuits have held that private parties may bring preemption claims under Spending Clause statutes even if Congress did not intend to make the statutes privately enforceable." Pet. 18. It

also concedes that "[t]he First Circuit. . .has indicated a willingness to allow private causes of action for preemption based on Spending Clause statutes even where the statute in question is not privately enforceable." Pet. 18 n.4. And, it acknowledges that "[s]everal other circuits [*e.g.*, Second, Third, Tenth]. . .have held that at least some preemption claims may be brought under non-Spending Clause statutes regardless of whether the federal statutes create privately enforceable rights." Pet. 18 n.4.

The only exception the Petitioner cites is the Eleventh Circuit, where it claims that the Court "has squarely held that 'the Supremacy Clause does not grant an implied cause of action,'" citing *Legal Envtl. Assistance Found., Inc. v. Pegues*, 904 F.2d 640 (11th Cir. 1990). Pet. 18, 19. However, petitioner misinterprets that decision and subsequent Eleventh Circuit case law. In *Pegues*, the alleged violation of federal law arose from the EPA Administrator's interpretation of federal law, which Alabama merely followed. The actual holding of *Pegues* was that "[b]oth [plaintiff] LEAF and the state agree that the proposed permits *comply* with the federal statute and regulations as they have been interpreted by the EPA. . . . LEAF's real dispute, therefore, is not with the state, but with the Administrator." *Id.* at 644 (emphasis added). The court noted that Congress had created an express cause of action against the federal agency, but the plaintiffs had not relied on that cause of action. The court therefore rejected the plaintiff's attempt "to bootstrap a statutory claim that should be

asserted against the Administrator into a constitutional issue" of preemption. *Ibid.* Premised as it was on the conclusion that plaintiff was simply suing the wrong government, *Pegues* does not conflict with the decisions of the other circuits.

The Eleventh Circuit's subsequent *en banc* decision in *BellSouth Telecommunications, Inc. v. MCImetro Access Transmission Services, Inc.*, 317 F.3d 1270 (11th Cir. 2003), demonstrates that petitioner has misread *Pegues*. *BellSouth* involved a suit by a phone company against a state public service commission claiming that the commission's decision was contrary to the Federal Telecommunications Act of 1996. The *en banc* court held that, apart from any express cause of action available under the statute, "[f]ederal courts must resolve the question of whether a public service commission's order violates federal law and any other federal question as well as any related issue of state law under its pendent state jurisdiction." *Id.* at 1278.

Moreover, this Court has repeatedly adjudicated claims by private parties asserting preemption by virtue of the Medicaid statute and other federal spending statutes. In *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), a Medicaid recipient sought a declaratory judgment that a state law was preempted by the Medicaid Act, and this Court unanimously agreed. In *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003), drug makers also brought an action asserting preemption of a state law under the Act. *See also*

Dalton v. Little Rock Family Planning Services, 516 U.S. 474, 476 (1996) (per curiam) (preemption under Medicaid); *Blum v. Bacon*, 457 U.S. 132, 138 (1982); *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 663 (1993); *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 269-270 (1985); *Pennsylvania Prot. & Advocacy, Inc. v. Houstoun*, 228 F.3d 423, 428 (3d Cir. 2000) (Alito, J.).

II. CERTIORARI SHOULD BE DENIED ON THE SECOND QUESTION BECAUSE THE DECISIONS BELOW ARE A CORRECT APPLICATION OF FEDERAL LAW

Petitioner contends that the Ninth Circuit's application of 42 U.S.C. § 1396a(a)(30)(A) is "atextual" and that it "conflicts with the holdings of every other circuit." Pet. 22, 24. Neither claim is correct.

A. The Court Of Appeals Correctly Applied 42 U.S.C. § 1396a(a)(30)(A)

42 U.S.C. § 1396a(a)(30)(A), the provision at issue in this case, provides that a state plan

> must. . .provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan. . .as may be necessary [1] to safeguard against unnecessary utilization of such care and services and [2] to assure that payments are consistent with efficiency, economy, and quality of care and [3] are sufficient

> to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (bracketed numbers added).

The decision below is fully consistent with the foregoing text. The plain language of the statute requires that States that participate in Medicaid "provide such methods and procedures" relating to "the payment for" medical care and services "to assure that payments are consistent with efficiency, economy, and quality of care." This language clearly requires that reimbursement rates be based upon an analysis of hospital costs sufficient to *assure* that payments are consistent with the efficiency, economy, and quality of care ("EEQ") factors.

The petitioner claims that 42 U.S.C. § 1396a(a)(30)(A) does not "require any type of study." Pet. 22. However, petitioner does not and cannot explain how it can otherwise "assure" that its "payments are consistent with efficiency, economy, and quality of care" without such a study. "Assure" is defined by Black's Law Dictionary as "to make certain and put beyond doubt." Black's Law Dictionary (6th ed. 1990). Without a study, petitioner cannot "make certain and put beyond doubt" that its payments are consistent with the EEQ factors.

Petitioner also claims that "a study would serve no useful purpose because rates are already based on providers' actual costs." Pet. 15. However, the fact that the rate reduction is based on actual costs doesn't obviate the need to study the effects of that rate reduction on the EEQ factors, nor does it mean that the rate, as reduced, would satisfy the EEQ requirements of Section 30(A).

Petitioner also objects to the requirement that the study be completed prior to the enactment of the rate reduction. This requirement exists because any consideration of the Section 30(A) factors is meaningful only if it actually impacts the rate setting process: "any analysis of reimbursement rates on the statutory factors of efficiency, economy, quality, and access to care, must have the potential to influence the rate-setting process." *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1109 (9th Cir. 2010). This is particularly true in cases like the instant one where the legislature is setting rates that cannot be changed by the state agency: "AB 1183 gives the Department no discretion to alter the rate cuts based on the Department's own analysis, and, therefore, the cuts were not 'based on' the Department's consideration of the relevant factors, but instead constituted a *post hoc* rationalization for a legislative decision that had already been made." *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 850 (9th Cir. 2009).

B. The Federal CMS Has Embraced The Ninth Circuit Analysis Of 42 U.S.C. § 1396a(a)(30)(A)

In *Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931 (9th Cir. 2005), the federal CMS rejected a state rate amendment on the ground that it was inconsistent with the statutory requirement of efficiency, economy, and quality of care. CMS disapproved the proposed amendment as inconsistent with Section 30(A) because the "proposed rates would substantially exceed the IHS [Indian Health Service] published rates" on which federal payments have historically been based. 424 F.3d at 937. It further explained that the IHS rates are "based on an analysis of statewide costs of the Alaska IHS facilities" and that, while it "might consider a request for a higher rate if supported by data showing costs that were not considered by IHS in setting the published rates, Alaska provided no such data to substantiate its proposed rates." *Id.* Hence, CMS concluded that, absent such data, the proposed rates "are not consistent with efficiency, economy, and quality of care" under Section 30(A). *Id.*

Thus, like the Ninth Circuit, CMS also requires that rates be based on a study of the EEQ factors.

C. The District Court Expressly Considered The Evidence Presented By The Petitioner And Correctly Rejected It

Prior to claiming that it relied on cost studies, the petitioner repeatedly argued that it was under no legal duty to consider cost studies when determining Medi-Cal rates under Section 30(A). In *Indep. Living Ctr. of Southern Cal., Inc. v. Shewry*, 2008 U.S. Dist. LEXIS 77525 (2008), petitioner claimed that "neither the Legislature, nor the Department has a duty to consider any particular factors or to conduct any particular studies."

Yet, in the district court here, the petitioner claimed that "there were three relevant studies before the Legislature prior to the enactment of AB 5" and that it conducted additional studies "[a]fter AB 5 was enacted, but prior to its July 1, 2008 implementation." Pet. 12. The District Court carefully reviewed each of these "studies" and correctly rejected them as not complying with the requirements of federal law.

One document the petitioner mentioned was the Legislative Analyst's Office ("LAO") Report analyzing the 2008-09 budget. According to the lower court, "the District Court for the Central District of California has already determined that 'all the Legislative Analyst's report shows is that such a report was prepared. Respondent has not shown that the Legislature ever reviewed or considered the concerns raised therein.'" Pet. App. 116. The lower court also stated that "[s]imilarly, here, Defendant has presented

no evidence that the Legislature or the Department ever reviewed or considered this report prior to setting the rate reductions that apply to Plaintiffs. Indeed, nowhere in the LAO Report is there any analysis of non-contract hospital costs." Pet. App. 116-117.

Another document referred to by the petitioner was the 2007 California Medical Assistance Commission ("CMAC") Annual Report. However, the district court found "that this report is irrelevant" because it "exclusively concerns contract hospitals, not the non-contract hospitals who are Plaintiffs in this case." Pet. App. 17.

The third document mentioned by the petitioner was the November 2005 analysis by the Department concerning a similar reimbursement rate reduction in 2004-2005. However, according to the lower court, the "Defendant presented no evidence that the Department or the Legislature actually reviewed it" and "[e]ven if they did, this document does not consider the impact of AB 5 on non-contract hospital costs." Pet. App. 17-18.

Relying upon the declarations of two Department employees, Liu and Wong, petitioner also contended that "the Department used the four-month period between the enactment and implementation of AB 5 to determine whether the reimbursement reductions satisfied the requirements of § 30(A)." Pet. App. 18.

According to the district court, "William Liu declares that the Department conducted an analysis

of the impact of [Cal. Welf. & Inst. Code] section 14166.245 prior to its implementation." Pet. App. 18. However,

> the document submitted to support this claim merely consists of annual estimates of recoupment collected by the PIRL program and percentages of total reimbursement for noncontract hospitals between 1999 and 2005. This document does not support the contention that the Director relied on responsible cost studies when adjusting the reimbursement rates at issue to determine whether these reimbursement rate reductions were consistent with efficiency, economy, quality of care, and access.

Pet. App. 18-19.

The district court also noted that Gary Wong had declared that "the Department analyzed whether the reduced reimbursement payments would be reasonable relative to hospitals' costs prior to implementation." Pet. App. 19. The court observed that Wong

> supports his claim by pointing to only two documents. The first is the November 2005 Analysis that the Court has already found inadequate to show that the Department complied with its statutory obligations. . .The second is a one-page, handwritten, summary comparison of how audited allowable costs compared to reported costs for unidentified noncontract hospitals between 2002 and 2005. . .This document is clearly inadequate to show the Department relied on

> responsible cost studies to determine that the ten percent reduction was consistent with efficiency, economy, quality of care, and access.

Pet. App. 19.

Based on the foregoing, the lower court concluded that "the Liu and Wong declarations and attached exhibits are not sufficient to show the Department complied with federal requirements." *Id.*

Thus, the district court carefully reviewed all of the information that the petitioner presented with respect to the EEQ factors, and correctly rejected it for the reasons set forth above.

D. The Decision Below Is Consistent With The Other Circuits

In *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1107 (9th Cir. 2010), the Ninth Circuit explicitly examined the approach used in other circuits and concluded that its "approach is consistent with that of our sister circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services before enacting rates."

The decisions cited by petitioner are irrelevant for a variety of reasons.

The Eighth Circuit decision in *Minn. Homecare Ass'n, Inc. v. Gomez*, 108 F.3d 917 (8th Cir. 1997) is not factually similar to the instant case because it involved an *increase* by three percent in reimbursement rates, rather than the substantial rate cuts at issue here. Although the agency in *Gomez* did not provide any formal Section 30(A) analysis to the legislature, lobbyists "actively participated in the. . .legislative session." *Id.* at 918. As a result, "the legislature adequately considered § 30(A) when it raised reimbursement rates[.]" *Cal. Pharm. Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010). *See also Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) (holding that a state agency "must consider the relevant factors of equal access, efficiency, economy, and quality of care as designated in [Section 30(A)] when setting reimbursement rates.")

The Third Circuit decision in *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999), is also not factually similar because it involved the application of rates that even the federal CMS (formerly HCFA) had noted were too high: "Pennsylvania had good reason to revise these rates. For several years prior to 1994, the HCFA had been advising the Department that its reimbursement rates were high, given, among other reasons, changes in the drug marketplace." *Id.* at 847. The Third Circuit did not, however, find the mandates of Section 1396a(a)(30)(A) to be unessential. It noted that the agency's "process of decisionmaking" must be "reasonable and sound," and

that an agency "may not act arbitrarily and capriciously." *Id.* at 852-853.

The Fifth and Seventh Circuit cases cited by petitioner are not relevant because they address only the "equal access" prong of Section 1396a(a)(30)(A), and do not address the EEQ requirements. In *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000), the Fifth Circuit considered only "the question whether recipients' access will be impaired."[3] *Id.* at 934. Similarly, in *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996), the Seventh Circuit reviewed the requirements of 42 U.S.C. § 1396a(a)(30) only in connection with the question of "equal access" and not EEQ. *Id.* at 1028-1029.

Contrary to petitioner's claim, the First Circuit never has addressed the EEQ issue because it concluded that Section 1396a(a)(30)(A) could not be enforced through Section 1983. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59-60 (1st Cir. 2004).

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[3] The Fifth Circuit decision in *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007) is also irrelevant because it considered only whether 42 U.S.C. § 1396a(a)(30)(A) conferred individual private rights that are enforceable under Section 1983, and never reached the application of the EEQ factors.

Thus, there is no conflict in the Courts of Appeals with respect to the meaning and application of the EEQ requirement, and thus no grounds for review.

III. THIS CASE IS A POOR VEHICLE FOR THE COURT'S REVIEW

There are a number of reasons why this case is a poor vehicle for the Court's review.

First, the opinion of which petitioner seeks review is an order sustaining a preliminary injunction, a posture that "of itself alone furnishe[s] sufficient ground" for denying review. *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916). Review of such interlocutory decisions is strongly disfavored because "many orders made in the progress of a suit become quite unimportant by reason of the final result, or of intervening matters." *American Constr. Co. v. Jacksonville, T. & K. W. Ry. Co.*, 148 U.S. 372, 384 (1893).

Second, this matter is not ripe for review because petitioner's rate changes have not been approved by the federal CMS. AB 5 was enacted on February 6, 2008, and instructed petitioner to "promptly seek any necessary federal approvals for the implementation of this section." *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, U.S. Supreme Court Case No. 09-0958, Pet. App. 160a. Also, federal law requires that "all plans receive approval by the federal government before they may be implemented, and that all amendments to plans must also be

federally approved." *Exeter Mem'l Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998). Despite these legal requirements, petitioner implemented the AB 5 rate cuts on July 1, 2008, without federal approval.

Furthermore, petitioner has intentionally stalled the federal review process. Petitioner submitted its state plan amendment to CMS on September 30, 2008, approximately three months after it implemented the AB 5 rate cuts. *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, U.S. Supreme Court Case No. 09-0958, Pet. App. 187a-210a. In December 2008, CMS responded with a nineteen-page request for additional information. *Id.* at Resp. App. 1a-20a. That letter concluded by explaining that the request for additional information "has the effect of stopping the 90-day clock with respect to CMS taking further action on this State plan submittal" and stating that a "new 90-day clock will not begin until we receive your response to this request for additional information." *Id.* at Resp. App. 20a. Finally, the letter stated that "[i]n accordance with our guidelines to all State Medicaid Directors dated January [2], 2001, we request that you provide a formal response to this request for additional information within ninety (90) days of receipt." *Ibid.*

It has now been over 24 months since CMS sent that letter and respondents are informed by CMS that, as of October 12, 2010, petitioner had still not responded. Under the guidelines referenced in the CMS letter, when a State does not respond to a request for additional information within 90 days, CMS

"will initiate disapproval action on the amendment." Letter from Timothy Westmoreland, Director, Health Care Finance Administration, U.S. Dep't of Health & Human Servs., to State Medicaid Directors, at 1 (Jan. 2, 2001), at http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf (last visited October 9, 2010).

Due to petitioner's extraordinary delay in responding to CMS's request for additional information, it is unclear if and when approval or disapproval of the AB 5 rate reduction will occur. If CMS disapproves the rate reduction, which appears likely based on its guidelines, then the issues in this case will become moot. This uncertainty makes this case an extraordinarily poor vehicle to address petitioner's claims.

Third, this Court does not grant review in cases unless a reversal would change the position of the parties in some concrete fashion. *See The Monrosa v. Carbon Black Export, Inc.*, 359 U.S. 180, 183 (1959). In this case, a reversal would not change the ultimate outcome of the case because respondents can seek the relief they want in State court by pursing a writ of mandate (Cal. Code of Civil Proc. § 1085). Indeed, the California courts have consistently compelled State officials to comply with provisions of the Medicaid Act, including the very statutory provision at issue in the instant case, 42 U.S.C. § 1396a(a)(30)(A). *See, e.g., Cal. Hospital Ass'n v. Maxwell-Jolly*, 2010 WL 3280274 (Cal. App. 1 Dist.) (2010); *Mission Hosp. Reg'l Med. Ctr. v. Shewry*, 168 Cal.App.4th 460 (2008),

rev. denied (Cal. 2009); *Cal. Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696 (2007); *Cal. Ass'n of Health Facilities v. Department of Health Servs.*, No. A107551, 2006 WL 3775842 (Cal. Ct. App. Dec. 26, 2006).

CONCLUSION

For the reasons set forth above, the petition for a writ of certiorari should be denied.

Dated: October 27, 2010

Respectfully submitted,

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22 CCR § 51545. Definitions

(a) The following definitions are applicable to Article 7.5 only unless otherwise specified in another section:

(1) Administrative Adjustment (AA) means the adjustment to a provider's PIRL in response to a provider's administrative adjustment request (AAR).

(2) Administrative Adjustment Request (AAR) means the provider's request for changes to the PIRL, which includes both the all-inclusive rate per discharge limitation (ARPDL) and peer grouping rate per discharge limitation (PGRPDL).

(3) Aligned ARPDs means the modified ARPDs which have been adjusted to estimate their value as of a common fiscal period ending for the purpose of computing the 60th percentile for the PGRPDL.

(4) All-Inclusive Rate Per Discharge (ARPD) means the per discharge dollar limit on Medi-Cal reimbursable costs prior to the application of the peer grouping inpatient reimbursement limitation (PIRL). The ARPD excludes return on owner's equity, disproportionate share payments and reductions for third-party liability (TPL), as referenced in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(5) All-Inclusive Rate Per Discharge Limitation (ARPDL) means a Medi-Cal inpatient reimbursement limit (MIRL) which is the all-inclusive rate per discharge (ARPD) multiplied by the number of Medi-Cal discharges. The ARPDL excludes return on owner's

equity, disproportionate share payments and reductions for TPL, as referenced in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(6) Allowable Rate Per Discharge (ARPD) means all-inclusive rate per discharge (ARPD).

(7) Atypical Case means Cost Outliers or Day Outliers.

(8) Base Period shall be for fiscal periods which begin on or after the effective date of Sections 51545 through 51557, the FPE immediately prior to the settlement period.

(9) Base Year means Base Period.

(10) Burden of Going Forward means the responsibility of a party to be the first one to present its evidence with respect to a particular issue.

(11) Burden of Proof means the responsibility of proving, by a preponderance of the evidence, the existence or nonexistence of each fact which is essential to demonstrate that a party's position regarding a disputed issue is correct.

(12) Case Mix means the mix in terms of the diagnosis related groups (DRGs) of the Medi-Cal patients served by the provider.

(13) Case Mix Index means an index that measures the average level of health care needed by a provider's Medi-Cal patients.

(14) Charitable Research Hospital means a provider which accepts catastrophically ill patients by referral only, has over 33 percent of their Gross Operating Expense (GOE) as charity care, over 1 percent of their GOE for research and has no obstetrics or nursery.

(15) Children's Hospital means in accordance with Section 14087.2 of the W&I Code, those hospitals where 30 percent of the infants and children served by the single institution qualify for Medi-Cal payment systems and the institution serves primarily children.

(16) Contract Services Costs means costs related to services provided that are covered by a contract with the Department for care of Medi-Cal inpatients, per W&I Code Section 14081.

(17) Contract Hospital means a provider that contracts with the Department, based on negotiations with the California Medical Assistance Commission (CMAC) in accordance with W&I Code Section 14081.

(18) Cost Outliers means those patients who have extraordinarily higher inpatient costs as identified by the cost outlier formulas in Section 51551.

(19) Cost Report means a report required by the Department and completed by the provider to determine the Medi-Cal Program's share of the provider's reasonable costs in accordance with applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(20) County Appropriations means the amount appropriated to the provider from the county general fund or other county sources for operating deficits or other operating needs. If a county hospital repays the county any portion of the appropriations, the repayment must be abated against current fiscal period appropriations.

(21) Customary Charges, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1, means those uniform charges allowed by Medi-Cal which are listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement.

(22) Crossover Patients means hospital inpatients who are eligible for both Medi-Cal and Medicare.

(23) Current Fiscal Settlement Period means the provider's accounting year for which a peer group inpatient reimbursement limitation (PIRL) is being determined.

(24) Day Outliers means those patients whose stay in the hospital is extraordinarily longer as identified by the day outlier formulas in Section 51551.

(25) Department means the California State Department of Health Services.

(26) Depreciation and Amortization means those amounts which represent portions of the depreciable

or amortizable asset's cost or other basis which is allocable to a period of operation.

(27) Diagnosis Related Group (DRG) means a group identified by certain clinically coherent types of patients who should have similar resource consumption within each of the universe of DRGs used in the Medicare Prospective Payment System (PPS), in accordance with applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(28) Discharge means the termination of lodging and a formal release of an inpatient by a provider. Deaths are counted as inpatient discharges. See Medi-Cal Discharge.

(29) Disproportionate Share Hospital means a provider whose Medicaid inpatient utilization rate (as defined in Section 1923(b)(2) of the Social Security Act) is at least one standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in the State, or where the providers's low income utilization rate (as defined in Section 1923(b)(3) of the Social Security Act) exceeds 25 percent.

(30) Economically and Efficiently Operated Providers means providers whose costs do not exceed the PIRL except for those costs that are otherwise found allowable by an AA or Formal Appeal process.

(31) Employee Benefits means the direct operating costs related to employee benefits consisting of FICA; State Unemployment Insurance (SUI) and

Federal Unemployment Insurance (FUI); vacation, holiday, and sick leave; group health insurance; group life insurance; pension and retirement; workers' compensation insurance; other payroll related employee benefits; and, other non-payroll related employee benefits.

(32) Employee Benefits Index means the factor resulting from the adjusted comparison of settlement period employee benefits expense to prior period employee benefits expense.

(33) Exempt Reimbursement means reimbursement not included in, or subject to limitation by the PIRL. These costs are limited to return on owner's equity and disproportionate share payments.

(34) Extraordinary and Unusual Events means an event of a sudden, unexpected, or unusual nature; e.g., avalanche, floods, earthquakes or other similar events whose circumstances are unavoidable regardless of the level of prudence exercised by the provider.

(35) Factor Input Price means the same as the Input Price Index.

(36) Final Peer Group Inpatient Reimbursement Limitation (PIRL) Settlement means a Departmental determination of liabilities owed resulting from a PIRL calculation based upon data audited or otherwise considered true and correct by the Department for the final settlement fiscal period, pursuant to the W & I Code Section 14170.

(37) Fiscal Period Ending (FPE) means the last day of a provider's fiscal period. A fiscal period is an accounting period established by the provider. The fiscal period is generally a twelve (12) consecutive month period; however, in some instances may be less than or exceed twelve (12) months.

(38) Fixed Costs means an operating expense or a class of operating expenses as a class, that does not vary with patient volume. Fixed costs are not fixed in the sense that they do not fluctuate or vary, but fluctuate or vary from causes independent of patient volume.

(39) Food Service Expense means those expenses for services and supplies related to the food service categories of: kitchen, dietary, and cafeteria.

(40) Formal Appeal means the provider's appeal of the Department's decision on an AAR concerning a final PIRL calculation.

(41) Formula Relief means changes in the ARPD that will carry forward into the next fiscal period's ARPD calculation.

(42) Gross Operating Expense (GOE) means the total operating expenses of the provider. This includes all expenses incurred in conducting the ordinary major activities of the provider inclusive of daily hospital services, ancillary services, research, education, general services, fiscal services and administrative services, including the physician professional component.

(43) Initial Base Period means the last fiscal period for each provider ending prior to the effective date of Sections 51545 through 51557.

(44) Input Price Index (IPI) means the weighted computation resulting in the reimbursable change in the prices of goods and services purchased by the providers (except for pass-throughs). The IPI shall consist of a market basket classification of goods and services purchased by providers, a corresponding set of market basket weights derived from each provider's own mix of purchased goods and services, and a related series of price indicators.

(45) Interim Payment Rate means the rate paid to a provider, expressed as a percentage, derived by the PIRL divided by provider's charges.

(46) Interest on Working Capital means a cost representing all interest incurred on borrowings for working capital purposes or interest on an unpaid tax liability.

(47) Interest, All Other means a cost representing all interest incurred for borrowings other than interest on working capital.

(48) Leases and Rents Costs means costs representing lease and rental expenses relating to occupying or using buildings, leasehold improvements and fixed assets not owned by the provider and not directly assignable to another cost center.

(49) Length of Stay Outliers means Day Outliers.

(50) Licenses and Taxes Costs means costs representing all license expenses and all taxes (other than tax on income).

(51) Malpractice Insurance (Hospital and Professional) Costs means costs representing liability insurance expenses, including premiums paid for physicians, the deductibles paid on claims, or the actuarially determined cost of self-insurance.

(52) Maximum Inpatient Reimbursement Limitation (MIRL) means the lowest of the following:

(A) Customary charges.

(B) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(C) ARPD limitation.

(53) Medi-Cal Discharges means those discharges where the inpatient services provided were covered by Medi-Cal for a Medi-Cal eligible beneficiary. This includes deaths, and eligible beneficiaries whose Medi-Cal covered services were paid in full or in part by third parties, if Medi-Cal was also billed for the services. Late paid claims where the patients' statistics were not included in the cost or audit report used to derive the PIRL and well newborns shall not be counted as Medi-Cal discharges. However, a well newborn whose mother is not eligible for Medi-Cal shall be counted as a discharge if the newborn is

eligible for Medi-Cal. Medicare crossover patients are not counted as Medi-Cal discharges if Medi-Cal paid only for any applicable deductibles and co-payments.

(54) MIRL Reimbursement Rate Per Discharge means the per discharge reimbursement amount under the MIRL, which has not been reduced for third-party liability, excluding any one-time relief, return on owner's equity and any disproportionate share payments. It is calculated by dividing the MIRL by the number of Medi-Cal discharges.

(55) New Hospital means any hospital:

(A) Which has a complete new physical plant that is less than three years of age and is not on the same or an adjacent property as the old physical plant; or

(B) Under new ownership, or resuming operations for the first time after a 12-month period (i.e. was closed for at least 12 months prior to being reopened under new ownership); or

(C) Which has operated under present and all previous ownerships for less than three years.

(56) New Service means an additional service developed and implemented by a Medi-Cal provider, to furnish and maintain quality inpatient hospital care to a patient population inclusive of Medi-Cal recipients.

(57) Newborn means an infant born in the hospital or delivered outside the hospital and admitted to the hospital shortly after birth.

(58) Noncontract Hospital means a provider that does not have a negotiated contract with the Department to provide medical care for Medi-Cal beneficiaries, pursuant to W & I Code Section 14081.

(59) Noncontract Service Costs means costs related to services provided to Medi-Cal inpatients, which are excluded from the provider's contract with the Department.

(60) Non-Pass-Through Costs means costs which are subject to the hospital cost index, as found in Section 51549.

(61) OSHPD means the Office of Statewide Health Planning and Development.

(62) One-Time Relief means changes in the ARPDL which only affect the settlement period and are not carried forward into the next settlement period ARPDL.

(63) OSHPD Accounting and Disclosure System means a uniform accounting and disclosure system designed by OSHPD.

(64) Outliers means Cost Outliers and Day Outliers.

(65) Partial Period Contracting Hospital means a contract hospital with a contract which covers only a partial fiscal period.

(66) Partially Contracting Hospital means a contract hospital with a contract that does not include all Medi-Cal covered services.

(67) Pass-Through Costs means cost categories for purposes of the ARPDL that are not subject to the hospital cost index. The categories are limited to: depreciation, rents, leases, interest, property tax, license fees, utilities and malpractice insurance, as defined in Section 51549.

(68) Per Diem means a daily rate paid for hospital services provided to Medi-Cal beneficiaries.

(69) Peer Group means a group of hospitals with similar characteristics that are grouped together for purposes of determining reimbursement limitations.

(70) Peer Grouping Inpatient Reimbursement Limitation (PIRL) means the lowest of the following:

(A) Customary charges.

(B) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(C) ARPDL.

(D) PGRPDL.

If a provider is exempt from the peer group limits, the Medi-Cal reimbursement limitation will be

the lowest of (A), (B) or (C), identified above. All references to PIRL include MIRL.

(71) Peer Grouping Rate Per Discharge Limitation (PGRPDL) means a Medi-Cal inpatient reimbursement limit. The PGRPDL excludes return on owner's equity, disproportionate share payments and reductions for third-party liability. The PGRPDL is the 60th percentile ARPD of each provider's peer group multiplied by the provider's number of Medi-Cal discharges.

(72) Pharmacy Expense means those expenses for services and supplies related to the pharmacy. The cost of drugs dispensed to inpatients are also included in this category.

(73) Primary Health Service Hospital means a provider that is either (1) located outside of a standard metropolitan statistical area, and located at least 15 miles from another licensed acute care hospital, and has 60 or fewer acute care beds; or (2) is located at least 20 miles from any other licensed acute care hospital, and has 60 or fewer acute care beds; or (3) be the only licensed acute care hospital in the county, and has fewer than 100 acute care beds as defined by Health and Safety Code Section 1339.9.

(74) Prior Fiscal Period means the most recent fiscal period ending prior to the period in which a PIRL is being determined.

(75) Productive Hours means the total paid hours less hours not on the job. Hours not on the job

include: vacation time; sick time; holidays; and other paid time off.

(76) Productive Salaries means the total direct payroll costs for productive hours related to a given classification.

(77) Professional Fees means fees for professional services consisting of medical (therapist and others); consulting and management fees; legal; audits; registry nurses and contracted services.

(78) Provider means an institution in California that furnishes inpatient hospital services to Medi-Cal beneficiaries.

(79) Purchased Services means costs related to services purchased from outside contractors.

(80) Rate Per Discharge means ARPD.

(81) Reasonable Costs means reimbursable costs as defined by 42 CFR, Part 413 and HCFA Publication 15-1.

(82) Recalculated Final PIRL Settlement means a final PIRL settlement which has been recalculated.

(83) Reimbursable Costs means those costs that are reimbursed as determined by the PIRL.

(84) Replacement Service means a newly implemented service which replaces another service in whole or in part.

(85) Rural Hospitals means consistent with Section 1188.855 of the Health and Safety Code, an acute care hospital which meets the criteria within peer group six (rural hospitals) as defined in the report entitled, "Hospital Peer Grouping for Efficiency Comparison" dated December 20, 1982.

(86) Salaries and Wages means the direct operating costs related to salaries and wages, consisting of: management and supervision; technicians and specialists; registered nurses; licensed vocational nurses; aides and orderlies; clerical and other administrative; environmental and food services; non-physician medical practitioners; and other salaries and wages. Those salaries and wages related to students from the medical education centers as well as physicians are not included here.

(87) Salary and Wage Index means the factor which is defined as part of the calculations in Section 51549(b)(2)(A)1.

(88) Second Level Appeal means Formal Appeal.

(89) Service Intensity means changes in the character of the services provided to each patient including but not limited to: changes in applicable technology; qualitative and quantitative changes in: personnel; supplies; drugs; and other materials. Service intensity does not include changes in the types of patients and illnesses treated.

(90) Settlement Fiscal Period means the provider's accounting period for which a PIRL settlement is being or has been conducted.

(91) Sixtieth Percentile means the point at which sixty percent (60%) will be below in any given group arrayed in order.

(92) Sixtieth Percentile ARPD means the maximum reimbursement per discharge under the PGRPDL system. It is the sixtieth percentile rate per discharge for each peer group.

(93) Sole Community Hospital is defined in 42 USC, Section 1395ww(d)(5)(C)(iii).

(94) Student and Physician Professional Fees means fees charged for the professional services provided to patients by hospital-based physicians and students. These do not include those fees related to the education, research and administrative duties performed by the hospital-based physicians.

(95) Student and Physician Salaries and Wages means the compensation (exclusive of in-service education), of students in teaching programs and physicians including such items as research, education program activities, general hospital administration, patient care and supervision.

(96) Tentative PIRL Settlement means the Department's determination of liabilities owed, resulting from a PIRL or MIRL calculation using unaudited cost report data provided by a provider.

(97) Third-Party Liability (TPL) means amount owed for hospital inpatient services on behalf of a Medi-Cal eligible beneficiary by any payor other than Medi-Cal.

(98) Total Hospital Gross Revenue means the amount of total charges for services rendered to all patients.

(99) Total Medi-Cal Gross Revenue means the amount of charges to Medi-Cal for services rendered to Medi-Cal eligible patients.

(100) Total Paid Hours means the sum of the productive hours and the vacation time, sick time, holidays, and other paid time off for all employee classes related to daily hospital services, ancillary services, general services; fiscal services; and administrative services.

(101) Utilities means the direct expenses, excluding telephone and telegraph expenses, incurred in the operation of the hospital plant and equipment, such as, but not limited to: electricity, gas and water.

(102) Variable Costs means operating costs that vary or fluctuate with changes in patient volume.

(103) Volume Adjustment means the adjustment for changes in patient volume that applies to the provider specific all-inclusive rate per discharge for a given fiscal period.

(104) Well Newborn means those newborns who have no major medical problems who are not counted

as Medi-Cal discharges. This includes newborns classified in Medicare PPS DRGs 372 and 373.

(105) Working Capital means the difference between total current assets and total current liabilities.

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22 CCR § 51546. Reimbursement Limits

(a) For provider fiscal periods beginning on or after the effective date of this Section, reimbursement for in-state hospital inpatient services provided to Medi-Cal program beneficiaries not fully covered by a negotiated contract as allowed in W&I Code Section 14081, shall be the least of the following four items except as stated in (b), (d), (f), (g), and (h) for each provider:

(1) Customary charges.

(2) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 Code of Federal Regulations (CFR), Part 413 and HCFA Publication 15-1.

(3) All-inclusive rate per discharge limitation (ARPDL).

(4) The peer grouping rate per discharge limitation (PGRPDL).

(b) The following adjustment shall be made to items (1) and (4) above:

(1) Providers shall also be reimbursed for disproportionate share payments if applicable.

(2) The least of the four items listed in (a)(1)-(4) above shall be reduced by the amount of third-party liability.

(c) Amounts determined under (a)(3) or (a)(4) above may be increased only by an AA or appeal.

(d) New hospitals and rural hospitals shall be exempt from the provisions of this Article relating to the MIRL and PIRL. New and rural hospitals shall be reimbursed in accordance with the lesser of subsections (a)(1) or (a)(2) above, and subject to any limitations provided for under federal law and/or regulation.

(e) Each provider shall be notified of the ARPDL and PGRPDL at the time of tentative and/or final PIRL settlements. If only a final PIRL settlement is issued, it shall take the place; of both the tentative and final PIRL settlement.

(f) Payments for Medicare covered services provided to Medicare/Medi-Cal crossover patients shall not be subject to the limitations specified in this Section. These services shall be reimbursed only for the Medicare deductibles and co-insurance amounts. The deductibles and co-insurance amounts shall not exceed the state reimbursement maximums. State reimbursement maximums shall be the interim rate

times charges after consideration of the Medicare payment.

(g) Payment for skilled nursing facility services shall be made in accordance with Section 51511.

(h) Payment for intermediate care facility services shall be made in accordance with Section 51510.

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22 CCR § 51547. Methods of Payment

(a) The methods of payment for inpatient hospital services under the MIRL shall include the following:

(1) An ARPD that shall be retrospectively established for each provider's tentative and final settlement fiscal period. The ARPD shall:

(A) Apply to all non-contract Medi-Cal inpatient covered services provided by the provider during its settlement fiscal period. It shall be based upon the statistics included in the providers Medi-Cal cost or audit report.

(B) Be updated annually to reflect reimbursable changes in factor input prices, service intensity, technology, productivity, patient volume, and other items as allowed through the AA and appeals process.

(2) An interim payment rate based upon an actual or projected reimbursable cost to charge ratio.

(A) The current interim payment rate shall be based on the lower of the following:

1. The latest tentative settlement fiscal period for which a final settlement has not been issued.

2. The latest final (which also includes recalculated finals) settlement fiscal period.

(B) Interim payment rates calculated under (A) may use data from settlements that have been previously issued if needed to determine the lower of 1. and 2. above.

(C) When newly-established providers do not have cost experience on which to base a determination of an interim rate of payment. In such cases, the Department will use the following methods to determine an appropriate rate:

1. If there is a provider or providers comparable in substantially all relevant factors to the provider for which the rate is needed, the Department will base an interim rate of payment on the reimbursable costs and customary charges of the comparable provider.

2. If there are no substantially comparable providers from whom data are available, the Department will determine an interim rate of payment based on the budgeted or projected reimbursable costs and customary charges of the provider.

3. Under either method, the Department will review the provider's cost and charge experience and adjust the interim rate of payment in line with the provider's cost and charge experience.

4. The Department may prohibit increases in the accommodation rates, as defined in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1, charged by the provider if the Department projects that such increases would cause their interim payments to exceed the PIRL.

5. Newly established providers may appeal their interim rate if it is based upon the criteria in (a)(2)(C)1. through 4., in accordance with the AAR procedures specified in Section 51550.

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22 CCR § 51548. Overpayments

(a) Interim payment rate adjustments and recovery of overpayments to providers shall be made at tentative or final settlement based upon the application of this Article.

(1) Such overpayments shall be collected and such interim payment rates shall be adjusted whether or not appeals of any audit, MIRL or PIRL for the current or any prior fiscal period have been filed by the provider.

(2) Interim payment rates calculated after the effective date of Article 7.5, Sections 51545 through 51557, and applied to services provided after the effective date of this regulation, shall comply with Sections 51547 and 51548 even if the actual settlement upon which the new interim rate is based, is not subject to this regulation.

22 CCR § 51549. Reimbursement Formula

(a) A hospital cost index (HCI) shall be established for each provider. This index shall consist of an input price index (IPI) and shall contain an allowance for changes in scientific and technological advancement, service intensity and productivity. The allowance shall be called the Service Intensity, Productivity, Scientific and Technological Advancement Factor (SIPTF).

(1) The HCI shall be calculated to account for actual changes in the IPI after the close of each provider's accounting period.

(2) The HCI shall be multiplied by the non-pass-through portion of the provider's MIRL reimbursement rate per discharge (tentative or final) for the prior fiscal period to determine the non-pass-through portion of its ARPD for the settlement fiscal period.

(A) The prior period shall always be the base period for each settlement.

(B) For the initial base period only, the non-pass-through portion of the ARPD shall be calculated as follows:

1. Step 1, add the amount of TPL for the initial base period to the MIRL (lowest of 51536(a)(1)-(3)) which includes amounts reimbursed under the AA and appeals process for the initial base period.

2. Step 2, recalculate Medi-Cal discharges for any initial base period in accordance with the definition of Medi-Cal discharges contained in Section 51545.

a. The Department shall notify the provider of the revised count of Medi-Cal discharges for the initial base period.

b. The provider may file an AAR on the count of Medi-Cal discharges for the initial base period only and only as it is used in the settlement period MIRL. The AAR must be filed within 60 days of notification of the number of Medi-Cal discharges for the initial base period.

c. The provider may file an appeal on the Department's response to the AAR in accordance with Section 51552.

3. Step 3, divide the result of step 1 by the result of step 2.

4. Step 4, multiply the percentage of non-pass-through costs for the initial base period by the result of step 3.

5. Use the result of step 4 in place of the PNPARPD in the ARPD formula in subsection (3) below.

(3) The ARPD shall be calculated as follows:

ARPD = PASPD + NPARPD.

= PASPD + (PNPARPD * HCI)

= (TPTC/THD) + (PNPARPD * ((AIPI * CMAF) + SIPTF))

Where ARPD = All-inclusive Rate Per Discharge.

PASPD = Pass through per discharge = TPTC/THD

TPTC = Total pass through costs in the settlement fiscal period

THD = Total hospital discharges in the settlement fiscal period.

NPARPD = Non-Pass-through All-inclusive Rate Per Discharge.

NPARPD = PNPARPD * HCI

PNPARPD = Prior year Non-Pass-through portion of the MIRL reimbursement rate per discharge which is,

((PMIRL – (PMCDIS * (PTPTC/PTHD)))/PMCDIS)

Where:

PMIRL = Prior fiscal period MIRL.

PMCDIS = Prior fiscal period number of Medi-Cal discharges.

PTPTC = Prior fiscal period total pass through costs.

PTHD = Prior fiscal period total hospital discharges

HCI = Hospital Cost Index =

((AIPI) ** (Days/730))* CMAF) + (SIPTF. **(days/730))

If the prior or settlement fiscal period is long (over 370 days) or short (under 360 days). If both fiscal periods are over 359 days and under 371 days HCI = (AIPI * CMAF) + SIPTF.

Where:

AIPI = Adjusted Input Price Index.

SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological advancement Factor.

Days = Sum of days in the current and prior fiscal periods.

CMAF = Case mix adjustment factor.

* = Multiplication.

** = Exponentiation.

(4) An annual allowance for service intensity, productivity and scientific and technological advancement shall be added to the allowable increase in the non-pass-through portion of the ARPD, as detailed in the formulas in this section. This allowance shall be in addition to reimbursement for pass-through

categories and shall be the net amount of changes for scientific and technological advancement, productivity improvement and service intensity, if any (excluding case mix), as recommended annually by the prospective payment assessment commission for the Medicare PPS for all FPEs during the PPS effective dates of the recommended allowance.

(5) The pass-through categories are those hospital cost categories which, for purposes of tentative and final settlement, are not subject to the HCI.

(6) Each pass-through category is listed below:

(A) Depreciation.

(B) Rents and Leases.

(C) Interest.

(D) Property Taxes and License Fees.

(E) Utility Expenses.

(F) Malpractice Insurance.

(b) An IPI shall be established to compute the reimbursable change in the prices of goods and services purchased by the providers (except for pass-throughs). The IPI shall consist of a market basket classification of goods and services purchased by providers, a corresponding set of market basket weights derived from each provider's own mix of purchased goods and services, and a related series of price indicators.

(1) Weights corresponding to market basket categories shall be derived and updated for each settlement fiscal period. These weights shall be computed using the latest available information from each provider's Medi-Cal cost report. If information from this source is not sufficient to establish a hospital specific weight for a particular market basket category, the Department shall assign a weight based on information from the United States National Hospital Input Price Index published by the Department of Health and Human Services, or other available sources.

(2) The IPI shall be calculated after the close of each hospital's FPE, to account for actual and/or estimated changes in the:

(A) Hospital specific wage and benefit rates.

1. The index for allowable changes in wages shall be computed as follows:

Salary and Wage Index (SWI) = CLSA/ACSA.

Where:

CLSA = Summation of (PYHx * CYHRx) for all x.

ACSA = Summation of all Actual Prior Fiscal Period Salaries for all x categories.

x = The following categories:

a. Technicians and Specialists.

b. Registered Nurses.

c. LVNs.

d. Aides and orderlies.

e. Clerical and other administrative.

f. Environmental and food service.

PYHx = Prior Fiscal Period Productive Hours.

CYHRx = Current (Settlement) Fiscal Period Hourly Rate = CYSx/CYHx.

CYSx = Current (Settlement) Fiscal Period salary Expense for each category.

CYHx = Current (Settlement) Fiscal Period productive Hours.

2. The Employee Benefits Index (EBI) shall be computed as follows:

EBI = (PYHT * CYBR)/PYB.

Where:

PYHT = Prior Year (Prior Fiscal Period) Paid Labor Hours for All Labor Categories.

CYBR = Current Year (Settlement Fiscal Period) Benefit Rate = CYB/CYHT.

PYB = Prior Year (Prior Fiscal Period) Benefits Costs.

CYB = Current Year (Settlement Fiscal Period) Benefits costs.

CYHT = Current Year (Settlement Fiscal Period) Labor Hours for All Labor Categories.

3. The SWI and EBI shall be annualized for any provider which has a short or long (under 360 or over 370 days) prior or current fiscal period.

(a) The SWI shall be adjusted using the following formula:

ASWI = SWI ** (730/Days).

ASWI = Adjusted SWI.

Where Days = Total days in the current and prior fiscal periods.

(b) The EBI shall be adjusted using the following formula:

AEBI = EBI ** (730/Days).

Where:

AEBI = Adjusted EBI.

Days = Total days in the current and prior fiscal periods.

(c) If the SWI and EBI are not annualized, then the ASWI = SWI and AEBI = EBI.

(B) Price indicators for other non-pass-through categories.

(C) Market basket weights for the following categories:

1. Salary and wages.

2. Benefits.

3. Professional fees, medical.

4. Professional fees, other.

5. Food.

6. Drugs.

7. All other non-pass-through costs.

(D) The non-pass-through costs "all other" category shall be weighted using the following weights for purposes of calculating the price indicator:

[See Table In Original]

(E) The weights for the seven market basket categories shall be the percentage of costs for each category as calculated from the Medi-Cal cost report.

(F) Each market basket weight shall be multiplied by the corresponding price indicator. The results will be summed to obtain the unadjusted non-pass-through price index.

(G) The price indicators for items under (C) (3 through 7) will be established for the end of each calendar quarter (March 31, June 30, September 30 and December 31). Any FPE other than on a calendar quarter shall use the price indicators under (C) above for the quarter in which the provider's FPEs.

1. The following five market basket categories and price indicators to be used in developing each provider's IPI are shown in the following table.

Non-Pass-Through Market Basket Classification (Excluding Wages and Benefits)

[See Table In Original]

2. The price index shall be 1.0 + the percentage increase in each service category as measured by the price indicator, expressed as a proportion.

(3) The formula for the hospital IPI shall be:

IPI = (PX1 * PGE1) + (PX2 * PGE2) + (PX3 * PGE3) + (PX4 * PGE4) + (ASWI * PGE5) + (AEBI * PGE6) + (PXO * PGE7)

Where:

IPI = Input Price Index.

PX1 = Price Index for Medical Professional Fees.

PX2 = Price Index for Other Professional Fees.

PX3 = Price Index for Food Costs.

PX4 = Price Index for Drug Costs.

ASWI = Adjusted Salary and Wage Index.

AEBI = Adjusted Employee Benefit Index.

PXO = Price Index for Other Costs.

PGE1 = Proportion of non-pass-through GOE which is for Medical Professional Fees for the prior fiscal period.

PGE2 = Proportion of non-pass-through GOE which is for Other Professional Fees for the prior fiscal period.

PGE3 = Proportion of non-pass-through GOE which is for Food Costs for the prior fiscal period.

PGE4 = Proportion of non-pass-through GOE which is for Drug Costs for the prior fiscal period.

PGE5 = Proportion of non-pass-through GOE which is for Salary and Wages for the prior fiscal period.

PGE6 = Proportion of non-pass-through GOE which is for Employee Benefits for the prior fiscal period.

PGE7 = Proportion of non-pass-through GOE which is for Other Costs for the prior fiscal period.

non-pass-through GOE = GOE minus total of all pass-through costs for the prior fiscal period.

(4) Providers that do not supply the data needed to calculate the IPI, shall have an IPI equal to the hospital market basket increase as calculated by HCFA, for the closest corresponding time period. For hospitals with short FPEs, the closest corresponding time period shall be the one with the closest mid-point.

(c) A volume adjustment shall be made to the provider's non-pass-through portion of the ARPD for the settlement fiscal period if the number of annualized total hospital discharges in the provider's settlement fiscal period differs from the number of annualized total hospital discharges in its prior fiscal period. The volume adjustment is used to allocate fixed costs on a per discharge basis. Provider fiscal periods (both settlement and prior) under 360 or over 370 days shall be annualized to a 365 day period based on the following formula:

ATHD = (365/DFP) * THD.

Where:

ATHD = Annualized total hospital discharges.

DFP = Days in fiscal period.

THD = Total hospital discharges.

(1) The volume adjustment shall be calculated using the following formula which adjusts the rate per discharge for estimated changes in average costs resulting from changes in volume.

VOLUME ADJUSTMENT FORMULA

AIPI = IPI * VAF

Where:

AIPI = Allowable change in the prior year non-pass-through portion of the ARPD after volume adjustment, expressed as a proportion. This is the adjusted IPI, which has not been annualized and does not include any CMAF or SIPTF.

IPI = Hospital Input Price Index.

[See Illustration In Original]

VAF = Volume Adjustment Factor

DIS[P] = Total hospital discharges in the prior fiscal period (annualized if needed).

VC = Variable cost as a proportion of total cost for the prior fiscal period.

* = Multiplication.

DIS[F] = Total hospital discharges in the settlement fiscal period (annualized if needed).

(2) Each provider's total costs, except for pass-through costs, shall be divided into the fixed and variable components shown in the following table. Data from the provider's Medi-Cal cost report or in the event it is unavailable, other direct report of expenses, shall be used to estimate the percentage of a provider's cost which varies with volume. A fixed to variable cost ratio of 50:50 shall be used when sufficient data from the provider are not available.

CLASSIFICATION OF FIXED AND VARIABLE COSTS

[See Table In Original]

(3) A provider may submit additional data on the classification of fixed and variable costs for review by the Department with the AAR. If these alternative classifications and/or data are accepted by the Department, the provider shall continue to:

(A) Utilize these accepted classifications of fixed and variable costs in all FPEs.

(B) Submit to the Department, along with their filed cost report, any required data on fixed and variable costs necessary to do the alternative calculations for all subsequent FPEs. If the provider fails to supply the data with the cost report, they shall have their interim payments reduced by 20 percent. If the data has not still been supplied 60 days after the 20

percent reduction in interim payments begins, the provider shall have their interim payments reduced by 100 percent until the data are supplied. The provider shall be given 30 days advance notice to supply the required data before any reductions in interim payments are applied under this subsection.

(4) All providers must supply the data items for each FPE necessary to do the PIRL calculations. The data must be supplied as part of each provider's Medi-Cal cost report.

(d) Summary of ARPDL formula for provider with full settlement and full prior fiscal periods:

(1) ARPDL = MCDIS *

(2) (((RENTS + LIC + PTAX + DEP + LEAS + INT + UTL + MPI) / THD) +

(3) (((PMIRL – (PMCDIS * (TPTCPP / PTHD))) / PMCDIS) *

(4) (((((PX1 * (MPFP / (GOEPP – TPTCPP))) +

(5) (PX2 * (OPFP / (GOEPP – TPTCPP))) +

(6) (PX3 * (FOODP / (GOEPP – TPTCPP))) +

(7) (PX4 * (DRUGP / (GOEPP – TPTCPP))) +

6 6

(8) ((S(PYH[k]*CYHR[k])/S(PYH[k]*PYHR[k]))*

k=1 k=1

(9) (SWP / (GOEPP – TPTCPP))) +

(10) (((PYHT * CYBR) / PYB) *

(11) (PYB / (GOEPP – TPTCPP))) +

(12) (PXO * (OTCP / (GOEPP – TPTCPP)))) *

(13) ((DIS[p] + (VC * (DIS[f] – DIS[p])))/DIS[f])) *

n m

(14) (((SDRGC[i])/MCDIS)/((SDRGP[j])/PMCDIS))) +

i=1 j=1

(15) (STA + PI + SI))))

Where:

ARPDL = All-Inclusive Rate Per Discharge Limitation.

MCDIS = Medi-Cal discharges in the settlement fiscal period.

RENTS = Rental costs for the settlement fiscal period.

LIC = License fees for the settlement fiscal period.

PTAX = Property Tax expenses for the settlement fiscal period.

DEP = Total allowable depreciation expenses for the settlement fiscal period.

LEAS = Lease expenses for the settlement fiscal period.

INT = Allowable Interest expense for the settlement fiscal period.

UTL = Allowable utility expenses for the settlement fiscal period.

MPI = Total Malpractice Insurance costs for the settlement fiscal period.

THD = Total hospital discharges for the settlement fiscal period.

PMIRL = MIRL (Lowest of rate, costs and charges) for the prior fiscal period.

PMCDIS = Medi-Cal discharges in the prior fiscal period.

TPTCPP = Total allowable pass-through costs for the prior fiscal period.

PTHD = Total hospital discharges for the prior fiscal period.

PX1 = Price index for medical professional fees.

MPFP = Allowable Medical Professional Fees for the prior fiscal period.

GOEPP = Gross Operating Expenses (GOE) for the prior fiscal period.

PX2 = Price index for Other Professional Fees.

OPFP = Allowable Other Professional Fees for the prior fiscal period.

PX3 = Price Index for Food costs.

FOODP = Allowable food costs for the prior fiscal period.

PX4 = Price Index for Drug costs.

DRUGP = Allowable costs for Drugs for the prior fiscal period.

PYH[k] = Prior fiscal period hours paid for employee classification k.

CYHR[k] = Settlement Fiscal Period Hourly Wage rate for employee classification k.

PYHR[k] = Prior fiscal period Hourly Wage Rate for employee classification k.

SWP = Allowable costs for salaries and wages for the prior fiscal period.

PYHT = Prior fiscal period paid hours.

CYBR = Settlement fiscal period hourly benefits rate.

PYB = Prior fiscal period benefits.

PXO = Price Index for Other Costs.

OTCP = Other allowable costs for the prior fiscal period.

DIS[p] = Total hospital discharges for the prior fiscal period.

VC = Variable cost proportion for the prior fiscal period.

DIS[f] = Total hospital discharges for the settlement fiscal period.

DRGC[i] = DRG weight for patient i in the settlement fiscal period.

n = Number of DRG weights in the settlement fiscal period.

DRGP[j] = DRG weight for patient j in the prior fiscal period.

m = Number of DRG weights in the prior fiscal period.

MCDISP = Medi-Cal discharges in the prior fiscal period.

STA = Adjustment factor for Scientific and Technological Advancement.

PI = Adjustment factor for Productivity Improvement.

SI = Adjustment factor for Service Intensity.

Lines 2 through 15 are the ARPD = All-Inclusive Rate Per Discharge.

Line 2 is the PASPD = Pass-through cost per discharge.

Line 3 is the PNPARPD = Prior fiscal period Non-pass through MIRL Reimbursement Rate Per Discharge.

Lines 4 through 12 are the IPI = Input Price Index.

Lines 4 through 13 are the AIPI – Adjusted Input Price Index.

Lines 4 through 15 are the HCI = Hospital Cost Index.

Line 8 is the SWI = Salary and Wage Index.

Line 10 is the EBI = Employee Benefits Index.

Line 13 is the VAF = Volume Adjustment Factor.

Line 14 is the CMAF = Case Mix Adjustment Factor.

Line 15 is the SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

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22 CCR § 51550. Administrative Adjustment Process

(a) A provider may request an AA to the ARPDL or PGRPDL established for that provider if the provider's cost based allowable reimbursement for the settlement fiscal period as defined by the lower of Sections 51546(a)(1) and (a)(2), exceeds or are expected to exceed the PIRL by over $ 100. Expected to exceed only refers to the settlement period being issued and not any future settlement fiscal periods. The burden shall be on the provider to estimate, using the PIRL settlement information provided by the Department and any other information they may have, if they will expect to exceed the PIRL by over $ 100.

(b) Items that are not subject to an AA or appeal include the following:

(1) The use of Medicare standards and principles of reimbursement.

(2) The reimbursement amounts determined in Section 51546(a)(1) and (a)(2).

(3) The method for determining the IPI.

(4) The use of all-inclusive reimbursement rates.

(5) The use of a volume adjustment formula.

(6) Disproportionate share payments (these are not reduced by application of the PIRL).

(7) Data reported on the cost report which has been audited or reviewed by the Department are considered true and correct pursuant to W&I Code Section 14170. Data that was incorrectly transferred from the providers' Medi-Cal cost or audit report and used to calculate the MIRL is subject to appeal.

(8) The methodology used to calculate the interim rate.

(9) Any prior fiscal period issues.

(10) Higher costs due to low occupancy.

(11) Items not reimbursed as part of the Medi-Cal cost report process as determined in Section 51546(a)(1) and (a)(2).

(12) Increased costs. Only the cause for the increased costs may be appealable, and then only if it is otherwise an appealable item.

(13) Any issue raised in a previous formal appeal for which a decision was made by the Department for the same provider. The only exception is to incorporate into the settlement fiscal period PIRL the prior decision in the same manner as it was previously decided by the Department. These only include

decisions made for FPEs affected by Sections 51545 through 51557. This does not include issues withdrawn by the provider and thus not determined on their merits in the formal decision.

(14) Increases in average length of stay.

(15) Changes in the Cost-Based Reimbursement System as determined under Section 51546(a)(1) and (a)(2).

(16) Increased costs incurred by entering into a contract which did not contain reasonable cost increase limitations.

(17) Increases due to increased costs or charges of a related party.

(18) Any issues involving labor cost increases except for those allowed in Section 51551(b).

(19) New services.

(c) Issues involving the following MIRL (or ARPDL but not PGRPDL) items may be resolved through an AA under the procedures in Section 51551:

(1) Changes in Medi-Cal case mix and outliers.

(2) Inappropriate calculation of fixed and variable costs.

(3) An error in the calculations.

(4) Determination of whether or not a provider is exempt from the ARPDL.

(5) Extraordinary and unusual events.

(6) Labor costs as allowed under Section 51551(b).

(7) Other causes of cost increases for costs which were economically and efficiently incurred for the necessary care of Medi-Cal inpatients, that are an increase on a per-discharge basis over the prior fiscal period and are not listed under (b) as not being subject to an AAR.

(8) The interim rate as it may be affected by changes resulting from items appealed under (1) through (7) above.

(d) If a provider's cost based reimbursement (lower of Section 51546(a)(1) and (a)(2)) exceeds both the ARPDL and the PGRPDL, the providers' AAR and any subsequent appeal of the AA, must address both limitations in order to obtain relief for both limitations. If only the ARPDL is appealed, no further appeal rights will exist for the PGRPDL at any later date, except for an AAR on a tentative PIRL settlement that is issued later as a final PIRL settlement.

(e) The procedures for requesting an AA of an ARPDL shall be as follows:

(1) A request for an AA of the ARPDL or PGRPDL, which the Department deems acceptable, shall be submitted within 90 days after notification of that limitation. These AARs must be postmarked or hand delivered on or before the 90th day after the postmark on the settlement notification letter. No

extensions shall be granted. If a settlement letter from the Department contains settlements for more than one fiscal period, 120 days shall be allowed to file the AAR.

(2) The AAR shall be submitted in writing to the Department and shall specifically and clearly identify each issue, the total dollar amount involved for each issue and the dollar amount of overlap among each issue. If the Department determines that additional data are needed, the provider shall have 60 days after notification of the Department's request to supply it to the Department. No extension shall be granted.

(3) The AAR need not be formal, but it shall be in writing and specific as to each issue in dispute, setting forth the provider's specific contentions as to those issues and the estimated amount each issue involves. If the Department determines that the request for any issue fails to state the specific grounds upon which objection to the specific issue is based, including the estimated dollar amount involved, the provider shall be notified that is does not comply with the requirements of this regulation and the issue cannot be accepted. If an issue is not accepted on this basis, the provider may not submit this issue as a formal appeal.

(4) All AARs must be signed by an employee of the provider authorized by the provider to do so or by an authorized representative.

(A) If the AAR is signed by an authorized representative, a signed statement of such authorization for each FPE must accompany the AAR signed by an appropriate employee of the provider.

(B) Each AAR must have a declaration attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative.

(5) For each issue other than those covered by one of the specific formulas in this section the provider must demonstrate either (A), (B) or all parts of (C) below:

(A) Data that was incorrectly transferred as specified in Section 51550(b)(7).

(B) An error was made in the rate calculation.

(C) All costs for which additional reimbursement are being requested were:

1. Economically and efficiently provided for the necessary care of Medi-Cal inpatients.

2. Not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed.

3. Not overlapped with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

(6) The request shall contain all the appropriate data to allow the Department to determine if relief is needed and to do the relief calculation.

(A) This may include, but is not limited to:

1. All internal/external reports concerning each issue;

2. All material presented to the hospitals' Governing Board concerning this issue;

3. Medical records for Medi-Cal patients;

4. Bank statements and canceled checks;

5. All financial statements;

6. Copies of contracts.

7. Copies of proposed and/or actual budgets.

8. The provider's suggested calculation for relief (for each issue specifically listed under Section 51551 below, the formula in regulation must be used).

(B) All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than one statement may be required if more than one data source is utilized.

(C) All data submitted may be audited by the Department.

(7) One-time relief may be granted for extraordinary and unusual events.

(A) The criteria for one-time relief is any item which occurred in one FPE and is not normally expected to apply to all future FPEs and therefore the ARPDL is not adjusted each future FPE for this issue.

(B) Formula relief shall only be granted for issues which are expected to carry on to every FPE.

(C) Relief for allowable increases in employee hours per discharge shall be one-time relief for the first two FPEs and then formula relief during the third FPE.

(8) The following steps are required by the Department for calculating relief:

(A) The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue.

(B) The provider shall identify the specific cause of the increased costs.

(C) The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues.

(D) The Department shall review the providers' figures on (A) and make any necessary corrections.

(E) The Department shall determine whether to grant one-time or formula relief.

(9) If data or other items requested by the Department for evaluation of an AAR are not supplied within 60 days, the Department shall suspend further consideration of this issue. If the requested data are not supplied within 120 days, the Department shall deem the AAR rejected for all issues for which the Department requested data or other items, and the provider shall be precluded from raising the issue(s) in a formal appeal.

(10) The provider shall be notified of the Department's decision in writing within 90 days of receipt of the provider's written request for an AA, or within 60 days of receipt of any additional documentation or clarification which was required by the Department, whichever is later. The request for an AA shall be deemed denied if no decision is issued within these time frames. The Department shall notify providers of such denials.

(11) A change in cost based reimbursable costs as defined in Section 51546(a)(1) and (a)(2), whether or not as a result of an audit appeals process, shall result in a redetermination of the PIRL, and shall not give rise to any additional appeal rights.

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22 CCR § 51551. Specific Administrative Adjustment Issues

(a) AAs for year-to-year changes in case mix and/or outliers under the ARPD (not the PGRPD) shall be resolved in the following manner:

(1) The case mix adjustment factor (CMAF) shall be calculated using the following steps:

(A) The provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:

1. The patient's last name and first initial.

2. Medi-Cal I.D. Number.

3. The admission date.

4. The discharge date.

5. The principal diagnosis code.

6. The total amount of billed charges.

7. The DRG number.

8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborn(s) and the mother must be listed separately on this listing, each with their own DRG and weight.

9. The sum of the cost weights and the number of Medi-Cal DRG discharges on the list. The number of Medi-Cal DRG discharges on the list must equal or exceed the number of audited Medi-Cal discharges. The listing must include all Medi-Cal patients, which includes newborns that are not counted as Medi-Cal discharges.

(B) The sum of the cost weights for each FPE shall be divided by their respective number of Medi-Cal discharges (not the number of patients in the listing) to obtain the average DRG weight for each fiscal period.

(C) The settlement fiscal period average DRG weight shall be divided by the prior fiscal period average DRG weight to obtain the CMAF.

(D) DRG cost weights used in this Section may be any set used by Medicare during any part of either the settlement or prior fiscal period.

The Department may also publish a set of Medi-Cal or California specific DRG cost weights, day outlier cutoffs and classifications as an option for the providers to use.

(E) Once a case mix adjustment index is granted, each subsequent fiscal period ARPDL shall include a CMAF (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMAF calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent

reduction to the provider's current interim payments. If the data is not received within 12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 6 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only.

(F) For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:

1. All DRG weights for all patients transferred to other acute care hospitals after being stabilized will be multiplied by 0.4 (a 60 percent reduction).

2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:

a. For each patient transferred list the charges from the hospital they were transferred to.

b. Divide each patient's charges at the provider's hospital by the patient's total charges (which includes charges from both the hospital they were

transferred to and the hospital they were transferred from).

c. Multiply the result of (b) for each patient by their DRG weight to obtain a new weight to use in the CMAF calculation.

3. The provider shall choose which option it will use. If the provider fails to specify an option in their AAR, the Department shall use option 1.

4. Outlier calculations for these providers shall be adjusted by using the costs and days for the patients while they are at both providers, and using the same allocation formula 1-3 above.

(2) Additional reimbursement shall be granted to approximate a hospital's increases, on a per discharge basis, in the marginal cost of care beyond specified thresholds that are already reimbursed for in the ARPDL, including the CMAF. AARs for additional reimbursement due to outliers (both cost and day outliers) shall be determined as follows:

(A) If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by:

1. The hospital shall also include on the listing required under (a)(1)(A) above the following additional items:

a. The length of stay for each patient.

b. The outlier cutoffs, in terms of both days and costs, as determined in accordance with Medicare

prospective payment rules and regulations for the applicable time period of each individual patient. However, whenever the Medicare formula uses a cost-to-charge ratio, the hospital specific cost-to-charge ratio shall be used. If the provider elects to use an alternative set of DRG weights published by the Department to calculate their CMAF, then the corresponding set of alternative outlier cutoffs must be used for each patient.

c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient.

d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows:

(1) The outlier cost cutoff shall be the greater of:

(A) A fixed dollar amount (adjusted for area wage levels) as defined in 42 CFR, Part 412.80(a)(ii)(A) for the appropriate service period.

(B) 1.5 multiplied by the ARPD multiplied by the DRG weight for the patient.

(2) The total costs for each patient shall be the overall Medi-Cal cost to charge ratio calculated from the cost report multiplied by the charges for each patient.

(3) The amount over the cost outlier thresholds, which is step (2) minus step (1), shall be multiplied by 0.80.

e. The cost to charge ratio is determined from the cost report for both the settlement and prior fiscal period.

2. If a patient qualifies as both a day and cost outlier, they shall be treated only as a day outlier.

3. Sum the amounts calculated in (2)(A)1.c. and d. above and divide by the respective number of Medi-Cal discharges for each FPE.

4. Relief shall be calculated by subtracting the prior fiscal period result of 3. from the settlement fiscal period result of 3.

5. Once an outlier adjustment, in conjunction with a CMAF, has been granted, it shall be included in all subsequent settlements even if it is a negative adjustment. Data necessary to do the outlier calculation shall be submitted each FPE within 9 months of the end of the FPE or current interim payments shall be reduced by 20 percent. If the data is not received within 12 months of the end of the FPE, the interim payments reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent.

(B) If a provider has not elected a case mix adjustment index, then relief for outliers shall be calculated as follows:

1. Providers shall provide lists containing the number of patients for every length of stay for both the settlement fiscal period and the prior fiscal period. For newborns not counted as separate Medi-Cal discharges, their days shall be added to their mother's.

2. The settlement fiscal period and prior fiscal period mean lengths of stay for all Medi-Cal patients shall be calculated by dividing total Medi-Cal patient days (including nursery days) by Medi-Cal discharges for each respective fiscal period.

3. Calculate the standard deviation of the length of stay for all patients in the prior fiscal period.

4. Compute 1.94 standard deviations of the mean length of stay in the prior fiscal period and add the result to the mean length of stay in the prior fiscal period.

5. Round the result in 4. above down to the next whole number to establish the outlier threshold to be used for both prior and settlement fiscal periods.

6. List the patients who exceeded the result of 5. above in either the settlement or prior fiscal period. Include in the list the patient's name, admission date, discharge date, length of stay and charges.

7. Calculate the amount of day outlier payments by:

a. Subtracting the result of 5. above from the length of stay of each patient whose stay exceeded the outlier threshold each FPE.

b. Sum the total days calculated in a. above for each FPE.

c. Divide the number from b. above by the number of Medi-Cal discharges in each respective FPE.

d. Subtract the prior fiscal period result of c. above from the settlement fiscal period result of c.

e. Multiply the result of d. above by the number of settlement fiscal period Medi-Cal discharges.

f. Calculate a per diem rate by dividing the settlement fiscal period MIRL by the total number of patient days (including newborn days).

g. Relief is calculated by multiplying the result of 7.e. above by the result of 7.f. above.

8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:

a. For both the prior fiscal period and settlement fiscal period, the provider shall provide a listing of the number of patients by charge category (in either $ 100 or $ 200 increments) in order to calculate the mean and standard deviation.

b. Calculate the mean charge per discharge and standard deviation for both FPEs.

c. Convert the means and standard deviations to costs per discharge, by using the allowable cost to charge ratio from the cost report for each respective FPE.

d. Calculate the increase in the cost per discharge by dividing the settlement fiscal period mean cost per discharge by the prior fiscal period mean cost per discharge.

e. Calculate the prior fiscal period cost outlier cutoff by adding 1.94 standard deviations to the mean cost per discharge.

f. The prior fiscal period charge cutoff shall be the result of step e. above divided by the prior fiscal period allowable cost to charge ratio from the cost report.

g. Calculate the settlement fiscal period charge outlier cutoff by multiplying the results of d. above by the result of f.

h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above:

(1) Last name and first initial.

(2) Admission date.

(3) Length of stay.

(4) Charges.

(5) Amount of charges over the threshold.

(6) Costs over the threshold, which is (5) multiplied times the cost to charge ratio from the cost report. Enter zero in this column for any patient who is a day outlier.

i. Sum the items under (6) above for both the prior and settlement fiscal periods (separately).

j. Adjust prior fiscal period costs to settlement fiscal period costs by multiplying the prior fiscal period item i. above result times the result of d. above.

k. Divide the results of prior fiscal period j. above and settlement fiscal period j. above by the respective number of Medi-Cal discharges each FPE.

l. Subtract the prior fiscal period result of k. above from the settlement fiscal period result of k. above.

m. Multiply the result of l. above (minimum of zero) by the settlement fiscal period number of Medi-Cal discharges.

n. Add the result of m. above to the MIRL and divide by the settlement fiscal period net cost of covered services.

o. Multiply the lesser of the result of d. above or 1.0 by the result of n. above to calculate the additional amount of relief for cost outliers who do not

qualify as day outliers. This cannot exceed the amount of the MIRL liability.

(b) AAs for changes in labor costs shall be resolved in the following manner:

(1) Relief from the SWI and EBI can be granted if, and only if, the basis is due to labor/benefit cost increases per discharge resulting from either the new adherence to existing requirements imposed by government regulations, rules, and/or statutes or the adherence to new requirements imposed by government regulations, rules, and/or statues. This includes new rules and new adherence to rules imposed by the Joint Commission on Accreditation of Health Organizations. The adherence to the regulations, rules, and/or statutes must be necessary to legally render the provided services to Medi-Cal recipients.

(2) The Department will be authorized to grant relief if the provider meets the criteria for relief. Any relief granted shall be based upon an analysis of labor costs both prior and subsequent to the effective date of adherence to the requirements. Any request for relief will require the following:

(A) A summation of the governmental requirements necessitating the increase in labor costs;

(B) Additional hours and staff required to adhere to the governmental requirements. The request will specify:

1. The exact title(s) of the added staff;

2. The appropriate employee cost category; and

3. The number of hours and hourly rates for each added or deleted staff member.

(C) Source of the additional support, e.g., new hire or transferred from another employee classification; and

(D) The appropriate pages of the Medi-Cal cost report reflecting the additional costs associated with the increased hours.

(3) A separate request shall be rendered for each affected cost center. The cost centers for appeal purposes shall be the exact same cost centers as disclosed in the provider's Medi-Cal cost report as audited by the Department. Relief may be granted only for those cost centers that incurred the expenses as the result of governmental requirements.

(4) The Department shall evaluate the submitted data to determine any changes in the following areas for each affected cost center:

(A) Labor hours per discharge;

(B) Labor costs per discharge;

(C) Changes made in other employee classifications that resulted in labor cost increases or decreases.

(5) The unit measure of change shall be the ARPD. Any relief granted shall be on a per discharge basis by adjusting the ARPD to incorporate the

increased, if any, labor costs per discharge which were not reimbursed in the ARPD and which do not overlap with any other issues. Any adjustments necessitated by the application of relief shall impact the base rate per discharge and will be carried forward into future settlements.

(6) The only basis for relief under Subsection (b) of 51551 shall be:

(A) Increased employee hours per discharge; or

(B) The requirement to employ more expensive labor, e.g., replace Aides with Registered Nurses.

(7) Requests for relief on the basis of increased patient acuity will be deferred to Section 51551(a). Patient acuity or service intensity shall not be entertained under Section 51551(b).

(8) Relief sought on the basis of labor disputes shall not be granted. Labor disputes are inclusive of, but not limited to, strikes, arbitration, and/or labor issues where employees in an organized, collective, or unified movement refrained from physically reporting to perform their routine duties or physically reported but refrained from performing their routine duties.

(9) Relief shall not be granted under 51551(b) as the result of circumstances created when the provider switched to or from nursing services instead of salaried personnel.

(c) The following steps will be used for calculating relief for any ARPDL issues not otherwise specified in this regulation:

(1) The provider shall clearly identify the issue and estimated dollar amount of relief.

(2) The provider shall determine what is the specific underlying cause of the increased costs. If the underlying cause of the increased costs is not clearly stated, the AAR shall not be accepted by the Department.

(3) The provider shall calculate what reimbursement, if any, is already included in the ARPDL due to this issue (such as pass-throughs or case mix covering a new service) and shall also calculate any overlap between this and other AA issues.

(4) The Department shall review and correct if necessary, the provider's calculations in steps 1 through 3 above.

(5) The Department shall subtract any overlap with other issues from the amount determined in steps 1 through 3 above.

(6) The Department shall determine if relief is "one-time" or "formula."

22 CCR § 51552. AA Formal Appeals Process

(a) A provider may appeal the Department's decision on the AAR for a final PIRL settlement only. There shall be no appeal on an AAR for a tentative PIRL settlement. The appeal shall be filed and conducted in accordance with the applicable procedural requirements of Article 1.5, except as modified by this section, including the following:

(1) The appeal shall be submitted within 30 days after notification of the Department's decision on the AAR.

(2) The provider shall present its issues and evidence first at the hearing, as they shall have the burden of going forward.

(3) The provider has the burden of proof of demonstrating by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.

(4) In order to demonstrate that it is entitled to relief from the PIRL and that the AA decision should be overturned, the provider has the burden of demonstrating by a preponderance of the evidence that the Department's AA decision is inconsistent with the applicable regulatory provisions and that the provider's alternative is consistent with the applicable regulatory provisions.

(5) If the Department's AA decision is proved, by a preponderance of evidence, inconsistent with the applicable regulatory provisions, and the provider has

not proved by a preponderance of the evidence that its position is consistent with the applicable regulatory provisions, then the Administrative Law Judge (ALJ) may fashion whatever relief is necessary to obtain consistency with the applicable regulatory provisions.

(6) Items that are not subject to an AA, as specified in Section 51551, shall not be subject to appeal.

(7) The provider shall be paid at the PIRL initially determined by the Department pending determination of a formal appeal.

(8) Any underpayments, identified in the appeal decision, shall be repaid to the provider, together with interest computed at the legal rate of interest beginning the later of the date the payment is received by the Department or the date the appeal is formally accepted by the Department.

(9) The evidence to be submitted by the provider at a formal appeal hearing that was not provided to the Department nor specifically and individually identified as available to the Department, during the AA process excluding oral testimony, must be submitted to the Department 30 days before the scheduled date of the hearing. The only exception, is when a hearing is scheduled within 45 days from the date notice is given. In this latter case, evidence must be submitted 15 days before the scheduled date of the hearing. Failure to submit this information

within the specified time frames shall result in its exclusion from the formal appeal hearing and record.

(10) Recalculation of the PIRL due to an appeal decision shall not give rise to any further appeal rights.

(11) If results of an audit appeal of the cost report or any prior fiscal period PIRL, AA or appeal, change data used in the settlement fiscal period PIRL, the PIRL shall be recalculated. The recalculation shall not give rise to further appeal rights.

(12) If an issue in an AAR is not accepted pursuant to Section 51550(e)(2) and (e)(3), the ALJ may only consider the evidence that was presented in the AAR and not any additional information or testimony. If the ALJ determines that the issue should have been accepted, the issue shall be remanded for a response to the merits.

(13) Only those issues that were clearly identified in a timely filed AAR, including an estimated dollar amount for each issue may be accepted as issues on a formal appeal.

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22 CCR § 51553. Peer Grouping

(a) Hospital reimbursement shall, unless exempted from or modified by the provisions of this section, be payable at no more than the 60th percentile aligned ARPD of the peer group to which the hospital is assigned by the Department. This limit is

the Peer Group Rate Per Discharge Limitation (PGRPDL). The peer groups shall be based on a classification of hospitals as determined in the 1991 Hospital Peer Grouping Report published by the Department, that combines individual hospitals in a unit on the basis of similar or common characteristics. The following peer group classifications will be used:

(1) University Teaching Hospitals.

(2) Major (non-university) Teaching Hospitals.

(3) Large Teaching Emphasis Hospitals.

(4) Medium/Small Teaching Emphasis Hospitals.

(5) Extremely Large Sized Hospital.

(6) Large Sized Hospitals.

(7) Moderately Sized Hospitals.

(8) Medium Sized Hospitals.

(9) Moderately Small Sized Hospitals.

(10) Very Small Sized Hospitals.

(11) Acute Psychiatric Hospitals.

(12) Alcohol-Drug Rehabilitation Hospitals.

(13) Combination Psychiatric/Alcohol/Drug Rehabilitation Hospitals.

(14) Psychiatric Health Facilities.

(15) Psychiatric Teachering Hospitals.

(16) Psychiatric Children's Hospitals.

(17) Moderate Alcohol-Drug Rehabilitation Emphasis Hospitals.

(18) Moderate Psychiatric Emphasis Hospitals.

(19) State Hospital – Veterans Home.

(20) State Hospital – Mental Health.

(21) State Hospital – Developmental Services.

(22) Children's Hospitals.

(23) Crippled Children's Hospitals.

(24) Rehabilitation Hospitals.

(25) Large Rehabilitation Emphasis Hospitals.

(26) Respiratory Specialty Hospitals.

(27) Student Health Centers.

(28) Charitable Research Hospitals.

(29) Rural Hospitals.

(30) Specialty Teaching Hospitals.

(31) Prepaid Health Plan Hospitals.

(32) Prepaid Health Plan – Psychiatric/Alcohol-Drug Rehabilitation Hospitals.

(33) Prepaid Health Plan – Teaching Emphasis.

(34) Eye Hospitals.

(35) Women Hospitals.

(36) Dental/Outpatient Hospitals.

(b) The Department may review and change the number and definitions of peer groups and the peer group placement of individual providers.

(1) Providers shall be notified of all such reviews and resultant changes to the peer groups.

(2) For purposes of peer group placement, license beds shall be average licensed beds excluding any beds in suspense, in accordance with Section 1271.1 of the Health and Safety Code.

(3) All peer group assignments will be for all FPEs between July 1st and June 30th for each fiscal year.

(c) Providers exempted from application of the PGRPDL shall consist of new hospitals, rural hospitals, sole community hospitals, children's hospitals, crippled children's hospitals, charitable research hospitals, primary health service hospitals and hospitals in peer groups with less than five Medi-Cal providers.

(d) Providers with less than 15 Medi-Cal discharges in any FPE that covers over 360 days, shall be exempt from the PGRPDL for that FPE only.

(e) The peer group 60th percentile ARPD for each July 1-June 30 FPE shall be calculated by:

(1) Obtaining the ARPD for each provider for the FPE during the state's fiscal period (or use the

latest available if one is not yet available for the selected time period).

(2) Using actual or estimated rates of inflation, align the ARPD for each hospital to a July 1 to June 30 FPE.

(3) Locating the 60th percentile, by multiplying 0.6 times one more than the number of ARPDs in the peer group.

(4) Starting from the bottom of a list of ARPDs, ordered from the lowest ARPD at the bottom, up to the highest ARPD at the top, count up the number of ARPDs using the result of (3) above.

(5) Interpolate if necessary.

(f) The 60th percentile ARPD shall be updated quarterly.

(g) Once a final PIRL settlement is issued for a provider, the 60th percentile ARPD established in that provider's FPE shall not change, even though the final PIRL settlement may be reissued as a "recalculated final PIRL settlement" as a result of any appeal as well as other reasons for recalculation.

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22 CCR § 51554. Peer Group Administrative Adjustments

(a) A provider may request an AA of the reimbursement limits specified in this section and their

peer group placement at the time of tentative and final PIRL settlement.

(1) The request shall be made within 90 days after notification of the reimbursement limits and shall be made in accordance with the procedures specified in Section 51550.

(2) The burden of proof shall be on the provider to prove that the additional reimbursement sought meets all of the requirements under Section 51550 and that except where a specific formula in Section 51555 exists, the provider's cost per discharge of the item being appealed, exceeds the 60th percentile cost per discharge of the item being appealed.

(3) In addition to the items listed under Section 51550(b), the following items shall not be subject to an AA of the PGRPDL:

(A) The use of hospital peer groups.

(B) The use of 60th percentiles and the methods used to compute them.

(C) Changes in case mix.

(D) Costs associated with strikes, other labor stoppages or slow downs.

(E) The addition of new services.

(F) Costs due to low occupancy.

(G) Difference in the type, nature, or scope of items or services available whether or not provided,

between the provider and other providers in its peer group since differences in the actual services needed to be rendered are accounted for in the CMA as specified in Section 51555.

(H) Any other issue that is not a difference between the provider and other providers in their peer group.

(4) A provider may appeal the Department's decision on the AA for final PIRL settlements only. The appeal shall be in accordance with Section 51552.

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22 CCR § 51555. Peer Group Specific Administrative Adjustment Issue

(a) Differences in case mix (including outliers) between the provider and other providers in its peer group shall be determined for the PGRPDL using the following formula, but subject to reduction for overlapping issues as specified in Section (d) below:

MARD=PGL * CMA

Where: MARD=Maximum Allowable Rate per Discharge under the PGRPDL.

CMA=Case Mix Adjustment, which is the providers case mix index divided by the peer group 60th percentile case mix index.

PGL=Peer Grouping reimbursement Limit per discharge (60th percentile ARPD for the peer group if no adjustments have been made).

(1) Case mix indexes shall be based on DRGs and shall be computed using OSHPD patient discharge data for providers. Providers with an ARPD CMAF shall use data they are required to supply for the ARPD CMAF. However, the set of DRG weights used must be consistent for all providers in the peer group and shall be determined by the Department for each FPE.

(2) Providers shall be allowed to submit more accurate patient discharge data for their hospital. Any such patient discharge data must be submitted with the AAR. The data cannot be used until it is verified by the Department. The Department shall not accept data that it determines may not accurately reflect the provider's Medi-Cal patients.

(3) If OSHPD patient discharge data does not correspond with all provider's FPE, the closest FPE shall be used. Indices will be developed for a calendar year and for a July 1-June 30 FPE. The period which most closely corresponds to the providers FPE shall be used. Calendar year data shall be used for FPEs from October 1 through March 31 inclusive. July 1 through June 30 fiscal period data shall be used for all other FPEs.

(4) CMAs may be applied to any provider with a case mix index greater than the 60th percentile case mix index of its peer group.

(5) In addition to case mix relief, a provider shall be granted relief for outliers if the provider's outlier relief per discharge is greater than the computed

60th percentile outlier relief per discharge for all providers in the provider's peer group. The methodology used shall be as follows:

(A) Using OSHPD patient discharge data, and Medicare criteria for DRG outlier relief as specified in 42 CFR, Part 412, compute the total outlier relief for all providers in each peer group (using the same formula as listed in Section 51551-ARPD case mix and outliers). However, the cost outlier cutoff shall not vary within any one FPE worth of data.

(B) Convert the results under (1) above to outlier relief per-Medi-Cal discharge.

(C) Align the results of (B) above, in order from lowest at the bottom up to the highest at the top, and by counting up from the bottom to the n + 1 provider (n = # of providers in the peer group), compute the 60th percentile outlier relief per discharge for each peer group.

(D) If the requesting providers's outlier relief per discharge is greater than the 60th percentile outlier relief per discharge, the provider's MARD shall be increased by the difference of the two figures.

(6) These formulas shall be subject to the following limitations:

(A) Only those providers with 30 or more Medi-Cal discharges shall be included in the calculation of the 60th percentile outlier and case mix index per discharge. However, providers with under 30

Medi-Cal discharges may still receive relief using the formulas in this Section.

(B) Providers whose Medi-Cal discharge count per their OSHPD patient discharge data has more than a 50 percent variance from the appropriate Medi-Cal discharge figure from the cost report, after adjusting for well newborns who are included in the OSHPD patient discharge data but not counted as Medi-Cal discharges, shall be excluded from the 60th percentile calculation. Cost report figures shall be adjusted to estimate the calendar or fiscal period OSHPD data.

(C) If the provider requesting outlier relief has more than a 10 percent variance in Medi-Cal discharge figures (OSHPD patient discharge data vs. Medi-Cal cost report), or under 30 Medi-Cal discharges, the provider shall be required to submit its own data for use in the calculation. Such data must be for all Medi-Cal patients and include the patient's last name, ICD-9 primary diagnosis code, admission data, discharge date, DRG number, charges, patient's age, and OSHPD disposition code. The list shall be in admission date order.

(D) Providers may submit additional data to replace the OSHPD data. Any such data must be supplied with the AAR. Providers must supply a list in admission date order, containing each Medi-Cal patient's last name, ICD-9 code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code.

(7) For noncontracting hospitals that do not keep a patient for the full episode of care, the CMA formula will be modified by one of the following formulas:

(A) Use only 40 percent of the appropriate DRG case mix weight for patients treated by noncontract hospitals, or

(B) 1. Track each patient's record to the contract hospital they were transferred to, and

2. Sum the charges from both providers, and

3. Apply the percent of total charges from the noncontract hospital to the DRG weight.

(b) Differences in labor costs, caused by factors such as differences in location, between the provider and other providers in its peer group shall be calculated using the following formula, subject to reduction for overlapping issues as specified in Section (d) below:

MARD = (LRCAF * WRR * PGL) + ((1-WRR) * PGL)

Where:

MARD = Maximum Allowable Rate Per Discharge under PGRPDL

LRCAF = Labor Related Cost Adjustment Factor, which is the minimum of (WI / PGWI), (HWR / PGWR) and (HWD / PGWD).

WRR = Wage Related Reimbursement Proportion of PGRPD (and ARPD) Reimbursement limitation for this hospital, which is: (TWRC / GOE) * (36LIMIT – %PASS * NETCOST)) / (36LIMIT *%NON).

PGL = Peer group limit, which is the 60th percentile ARPD.

WI = The wage and benefit index for the area in which the hospital is located.

PGWI = Peer group 60th percentile WI.

HWR = Hospital aligned wage and benefit rate per hour.

PGWR – Peer group 60th percentile HWR.

HWD = Hospital aligned wage related items per discharge.

PGWD = Peer Group 60th percentile HWD.

TWRC = Total wage related costs (sum of wages, benefits, and professional fees).

GOE = Gross operating expenses.

36LIMIT = Maximum reimbursement under MIRL (lesser of costs, charges, and the ARPD multiplied by the number of Medi-Cal discharges).

%PASS = Proportion of GOE which are pass throughs from Report E, Part II, Line 3.

NETCOST = The lesser of net cost of covered services and charges.

%NON = 1 –%PASS, which is the proportion of GOE which are not-pass-through costs.

NOTE: * = Multiplication

(1) The labor adjustment formula starts by determining the portion of the MIRL that was allowed for Wage Related Reimbursement (WRR). Only this amount is adjusted by the minimum of:

(A) A ratio based on an area (Metropolitan Statistical Area (MSA)) index developed by the Department of Health and Human Services, calculated using aligned average hourly rates for all hospital employees. The provider's area index is divided by the peer group 60th percentile wage index.

(B) A ratio based on comparing the provider's aligned hourly rate to the 60th percentile aligned hourly rate of the peer group.

(C) A ratio based on comparing the providers's aligned wage related items per discharge to the 60th percentile aligned wage related items per discharge for the peer group.

(2) The first ratio is calculated as follows:

(A) Use Medi-Cal cost report data to determine the statewide average employee composition among all employee classifications.

(B) Adjust the wage and benefit rates for each provider to the adjusted rate using the statewide distribution of employees.

(C) Align the adjusted wage and benefit rates for each provider using OSHPD disclosure data. The alignment factors shall be a Department estimate of increases in salary levels.

(D) Sum the adjusted wages and benefits for each MSA and statewide.

(E) Sum productive hours by MSA and statewide.

(F) Divide the sum of wages and benefits by the sum of productive hours for each MSA and the statewide totals.

(G) Divide each MSA average hourly wage rate (Step 4.) by the statewide average to obtain an MSA index.

(H) Assign the index for each MSA to all hospitals in the MSA.

(I) Determine the 60th percentile index for each Peer Group.

(J) Divide the hospital's area index by the 60th percentile index of its peer group.

(3) The second ratio (in (A)2. above) is calculated by:

(A) Total the wages and benefits for all employees for each provider.

(B) Divide (A) above by the corresponding total productive hours for each provider.

(C) The Department shall estimate increases in employee hourly wage and benefit costs, and align the data in (B) above to a common FPE for all providers.

(D) Align all of the results of (C) above ordered from lowest at the bottom to the highest at the top for each peer group.

(E) Count (0.6 * (n + 1)) places up from the bottom of the list in each peer group to find the 60th percentile.

1. N is the number of hourly rates in the peer group.

2. Interpolation will be used whenever (0.6 * (N + 1)) is not a whole number.

(4) The last ratio is calculated by:

(A) Total the wages and benefits for all employees for each provider.

(B) Using Department estimates of rates of increase in employee hourly wages and benefit costs, align the data in (A) above to a common FPE for all providers.

(C) Divide the result of (B) above by the number of total hospital discharges.

(D) For each peer group, order from lowest at the bottom to the highest at the top the results of (C) above.

(E) Count (.6 * (n + 1)) places up from the bottom of the list in each group to find the 60th percentile.

1. N is the number of wage and benefit rates per discharge in the peer group.

2. Interpolation will be used whenever (.6 * (n + 1)) is not a whole number.

(c) Differences in capital costs between the provider and other providers in its peer group shall be resolved using the method specified in this subsection. Approval by the OSHPD of a capital expenditure shall be evidence of the need for the capital expenditure; however, such approval shall not, per se, compel additional reimbursement. The following methods shall be used to calculate relief under this issue:

(1) Using data from the Medi-Cal cost report, compute relief by:

(A) Removing the 60th percentile capital cost per discharge from the 60th percentile allowable rate per discharge.

(B) Computing the allowable provider Medi-Cal capital expense per discharge subject to the limitations in (E) below, and

(C) Adding the result of (A) above the result of (B) above.

(D) The resulting figure from (C) above will be used in place of the 60th percentile rate per discharge,

but to avoid overlap with any other issue, this adjustment shall be made last.

(E) The result of (1)(B) above shall be subject to the following adjustments:

1. A hospital which has had a change of ownership (CHOW) on or after July 18, 1984 must submit data showing what its capital costs would have been had the CHOW not occurred except for any additional costs allowed under the Deficit Reduction Act of 1984. This capital cost amount shall be used when computing the provider's capital per discharge figure above.

2. If a provider has had its capital costs reduced by Medicare, the provider's capital expense per discharge (CEPD) shall be reduced by the Medicare capital cost reduction percentage.

The formula for relief would then be:

MPGRPD = (PGRPD – 60th percentile CEPD) + (X * hospital CEPD)

Where: X = 1 minus the Medicare payment reduction percentage

3. If a provider's capital expense per discharge is above the 60th percentile, it shall not be entitled to automatic relief. The provider must still prove that the capital expenses are necessary for the care of Medi-Cal patients.

(d) Providers which are eligible for any multiple adjustments under Sections 51554 through 51555

shall have relief computed using the following methodologies:

(1) For providers which are eligible for case mix, labor and capital adjustments, relief shall be computed as follows:

MPGRPD = MAX(CMA,LRCAF,MIN ((CMA*(WI/PGWI), (HWD/PGWD))) * WRR * PGRPD) + (CMA * (1 – CRC – WRR) * PGRPD) + CEPD

Where: CRC = Capital related cost percentage (CEPD/GOE)

MIN= Minimum of the items in parentheses

MAX= Maximum of the items in parentheses

If the provider's CEPD has been modified per Section 51555(c)(2), that revised figure shall be substituted into the formula above.

(2) For providers which are entitled to a CMA but whose capital and/or labor costs per discharge are below the 60th percentile, those cost components shall not be adjusted by the CMAF. The formula for relief shall be:

MPGRPD = ((PGRPD – 60th percentile CEPD – 60th percentile labor per discharge) * CMA) + hospital CEPD + hospital labor per discharge

(A) This formula shall be modified to remove only those costs (labor and/or capital) which are below the 60th percentile limit.

(B) A provider's reimbursement, pursuant to the above, shall not be adjusted below the 60th percentile rate per discharge.

(3) All other multiple adjustments shall have their overlapping relief calculated using the basic PGARPDL principles.

(e) Differences in costs between the provider and other providers in its peer group due to extraordinary events beyond the provider's control such as fire, earthquake, flood, or similar unusual occurrences with substantial cost effects shall be an appealable item;

(f) Differences in costs between the provider and other providers in its peer group caused by other items or circumstances affecting provider costs which meet all of the following criteria:

(1) The item is a difference, on a per discharge basis, between the hospital and the 60th percentile of the peer group.

(2) The item can be measured or estimated for all providers in the peer group.

(3) The costs were necessary for the provision of quality medical care to Medi-Cal beneficiaries.

(4) There is no overlap with other issues or the overlap can be measured.

(g) Relief for any issue shall be reduced for any overlap between issues.

(h) Any additional reimbursement granted pursuant to this section shall not result in a recalculation of the 60th percentile limit under Section 51553.